Resident Physician

JOURNAL FOR THE HOSPITAL STAFF OFFICER

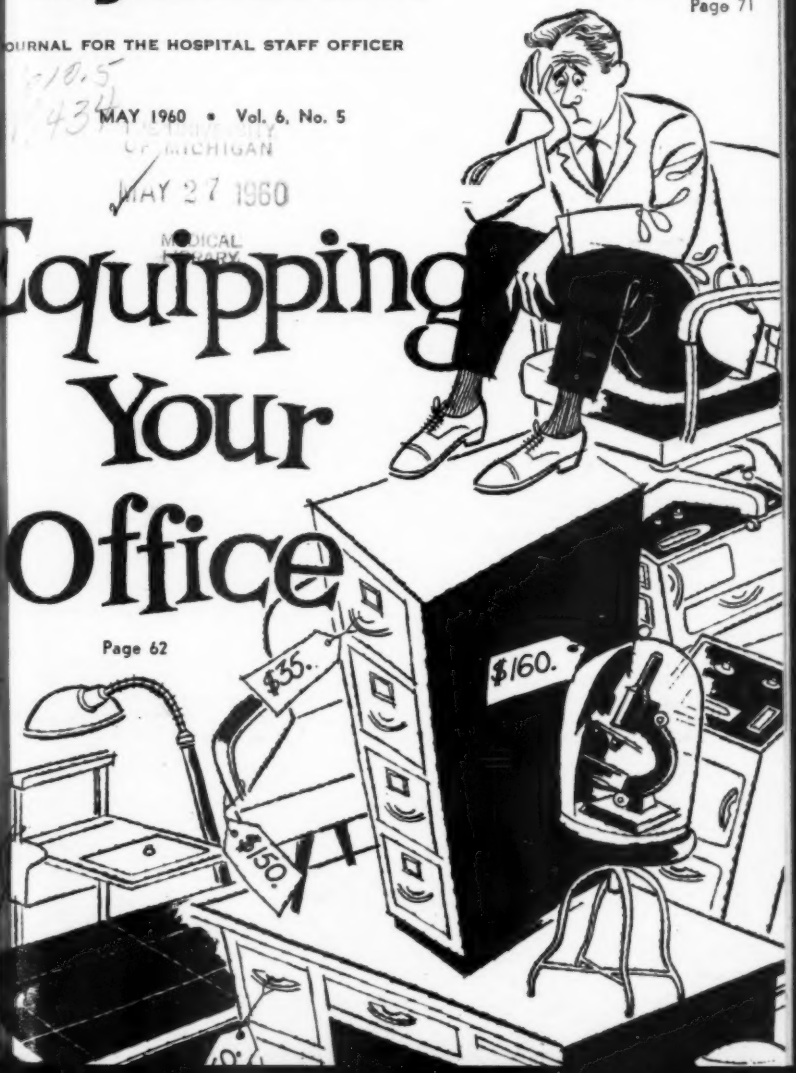
MAY 1960 • Vol. 6, No. 5

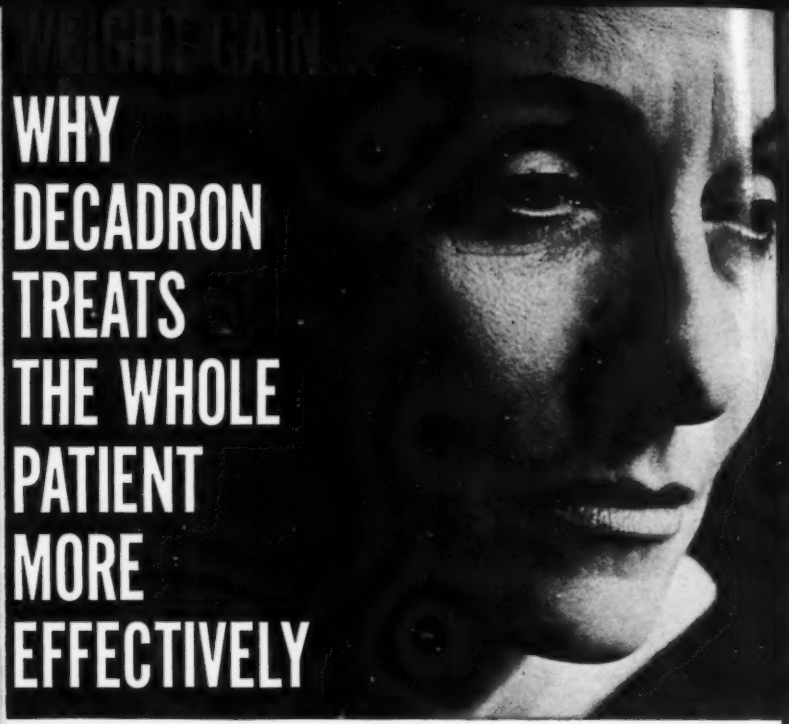
Last Call for Summer Camps

Page 71

Equipping Your Office

Page 62





WHY DECADRON TREATS THE WHOLE PATIENT MORE EFFECTIVELY

Patients with chronic rheumatoid arthritis or other collagen or allergic diseases often require the "tonic effect"[3] as well as the anti-inflammatory effects of dexamethasone. For them, DECADRON has relieved fatigue and weakness,[4,5] increased appetite[4-6] and often promoted a "real gain in weight"[6]—*"a definite therapeutic advantage in many patients requiring steroid therapy."*[7]

References: 1. Bunim, J. J., et al.: Arthritis & Rheumatism *1*:313, 1958. 2. Silverman, H. I., and Urdang, A.: Am. Prof. Pharm. *25*:531, 1959. 3. Rudolph, J. A., and Rudolph, B. M.: Ann. Allergy *17*:710, 1959. 4. Spies, T. D., et al.: South. M. J. *51*:1066, 1958. 5. Galli, T., and Mannetti, C.: Minerva med. *50*:949, 1959. 6. Segal, M. S., et al.: Ann. Allergy *17*:413, 1959. 7. Duvenci, J., et al.: Ann. Allergy *17*:695, 1959.

Supplied: As 0.75 mg. and 0.5 mg. scored, pentagon-shaped tablets in bottles of 100 and 1000. Also available as Injection DECADRON Phosphate.

Additional information on DECADRON is available to physicians on request.

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DEXAMETHASONE

'THE MOST POTENT STEROID"[1] WITH "THE LEAST NUMBER OF SIDE EFFECTS"[2]

MERCK SHARP & DOHME, Division of Merck & Co., INC., West Point, Pa.

May 1960, Vol. 6, No. 5

Resident Physician

May 1960, Vol. 6, No. 5

Articles

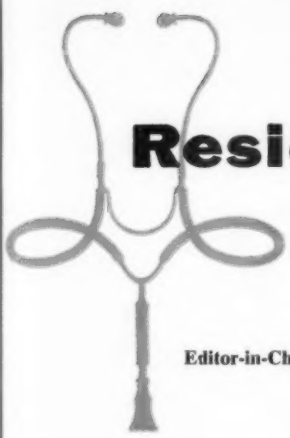
The Resident Physician is published monthly in the fifteenth by The Resident, Inc., with publication offices at 34 North Crystal Street, East Stroudsburg, Pennsylvania. Executive, advertising and editorial offices at 1447 Northern Boulevard, Manhasset, New York. If undelivered, please send form 3547 to Resident Physician, 1447 Northern Boulevard, Manhasset, New York.

Resident Physician

Departments

May 1960, Vol. 6, No. 5

Journal for the Hospital Staff Officer



Resident Physician

May 1960, Vol. 6, No. 5

Articles are accepted for publication with the understanding that they are contributed solely to this publication, and will directly interest or be of practical value to resident physicians and interns. When possible, two copies of the manuscript should be submitted.

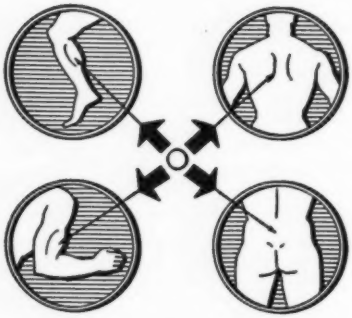
West Coast Representative: Ren Averill, Ren Averill Company, 232 North Lake Avenue, Pasadena, California. Subscription rate $10.00 per year. Single copies $1.00. Notify publisher promptly of change of address.

For Dependable Relief of Skeletal Muscle Spasm...

Two Tablets Per Day

Norflex™*

orphenadrine citrate



ADVANTAGES

- Mobility is restored quickly and associated pain relieved by prompt relaxation of muscle spasm.
- Prolonged action and potency provide round-the-clock benefits—including uninterrupted sleep.
- Impairment of general muscle tonus has not been reported when the recommended standard dosage is followed.

INDICATED IN ALL TYPES OF ACUTE MUSCLE SPASM following sprains, strains, whiplash injuries, intervertebral disc syndrone, chronic osteoarthritis, etc.

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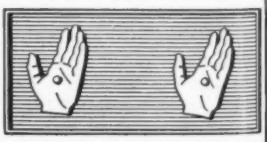


*Trademark U. S. Patent No. 2,647,351
Other patents pending

Riker
Northridge, California

Resident Physician

Anesthesiology

J. ADRIANI, M.D., Director, Department of Anesthesiology, Charity Hospital of New Orleans.

MAX S. SADOVE, M.D., Director, Department of Anesthesiology, University of Illinois.

Dermatology

MARION B. SULZBERGER, M.D., Professor and Chairman, Department of Dermatology and Syphilology, New York University Postgraduate Medical School.

General Practice

C. WESLEY EISELE, M.D., Chief, General Practice Residency Program, University of Colorado.

GEORGE ENTWISLE, M.D., General Practice Program, University Hospital, Baltimore.

Medicine

WILLIAM B. BEAN, M.D., Professor of Medicine, University of Iowa Medical School.

CHARLES DAVIDSON, M.D., Associate Professor of Medicine, Harvard Medical School.

C. WESLEY EISELE, M.D., Associate Professor of Medicine; Assistant Dean in Charge of Post Graduate Medical Education, University of Colorado.

CHARLES L. LEEDHAM, M.D., Director of Education, Cleveland Clinic, Frank E. Bunts Educational Institute.

JOHN C. LEONARD, M.D., Director, House Staff Education, Hartford Hospital.

Obstetrics-Gynecology

ALAN F. GUTTMACHER, M.D., Director, Department of Obstetrics and Gynecology, Mt. Sinai Hospital, New York City.

Ophthalmology

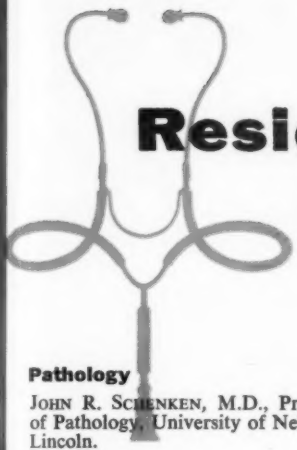
DERRICK T. VAIL, M.D., Chairman, Department of Ophthalmology, Northwestern University Medical School.

Orthopedics

HAROLD A. SOFIELD, M.D., Professor of Orthopedic Surgery, Northwestern University Medical School.

Otolaryngology

DEAN M. LIERLE, M.D., Chief, Department of Otolaryngology and Maxillofacial Surgery, State University of Iowa.



Resident Physician

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ACTS FASTER—usually within 5-15 minutes. **LASTS LONGER**—usually 6 hours or more. **MORE THOROUGH RELIEF**—permits uninterrupted sleep through the night. **RARELY CONSTIPATES**—excellent for chronic or bedridden patients.

AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Federal law permits oral prescription.

Each PERCODAN® Tablet contains 4.50 mg. dihydrohydroxycodeinone hydrochloride, 0.38 mg. dihydrohydroxycodeinone terephthalate, 0.38 mg. hpmatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. phenacetin, and 32 mg. caffeine.

Also available — for greater flexibility in dosage — PERCODAN®-DEMI: The PERCODAN formula with one-half the amount of salts of dihydrohydroxycodeinone and homatropine.

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Percodan®

Salts of Dihydrohydroxycodeinone and Homatropine, plus APC

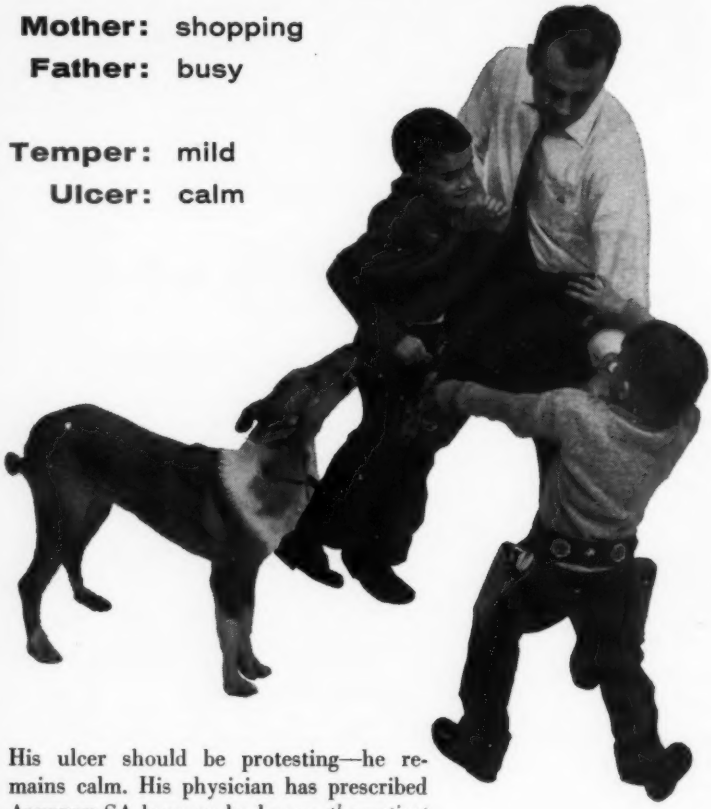
U.S. Pat. 2,628,185

Therapeutic Reference

The following index contains all the products advertised in this issue. Each product has been listed under the heading describing its major function. By referring to the pages listed, the reader can obtain more complete information. All products are registered trademarks, except those with an asterisk(*).

Mother: shopping
Father: busy

Temper: mild
Ulcer: calm



His ulcer should be protesting—he remains calm. His physician has prescribed ALUDROX SA because he knows *the patient as well as the ulcer must be treated.*

• calms emotional distress • promotes healing • reduces acid secretion • relieves pain • inhibits gastric motility

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A Century of Service to Medicine

a new infant formula

nearer to mother's milk in nutritional breadth and balance

Enfamil*

Infant formula

Enfamil

NEARER . . . in caloric distribution of protein, fat and carbohydrate

NEARER . . . in vitamin pattern (vitamin D added in accordance with NRC recommendations)

NEARER . . . in osmolar load

ENFAMIL IS ALMOST IDENTICAL to mother's milk in

- ratio of unsaturated to saturated fatty acids
- absence of measurable curd tension . . . enhances digestibility

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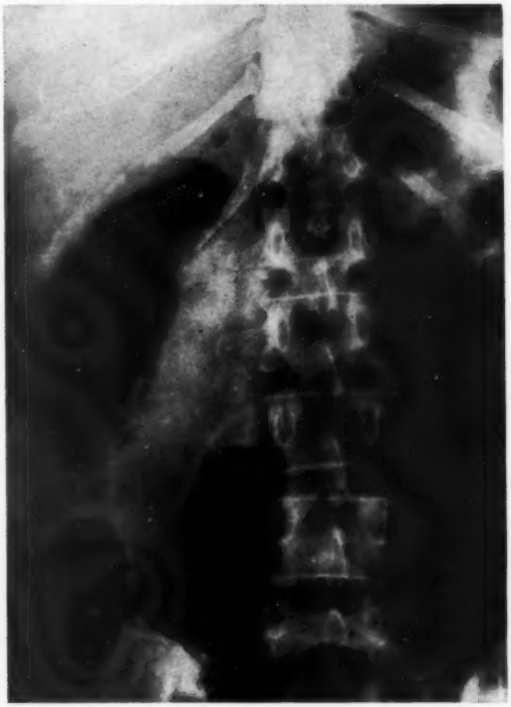
Symbol of service in medicine

Viewbox Diagnosis

Edited by Maxwell H. Poppel, M.D., F.A.C.R.,
Professor of Radiology, New York University College of Medicine
and Director of Radiology, Bellevue Hospital Center

Fifty-seven-year-old female.

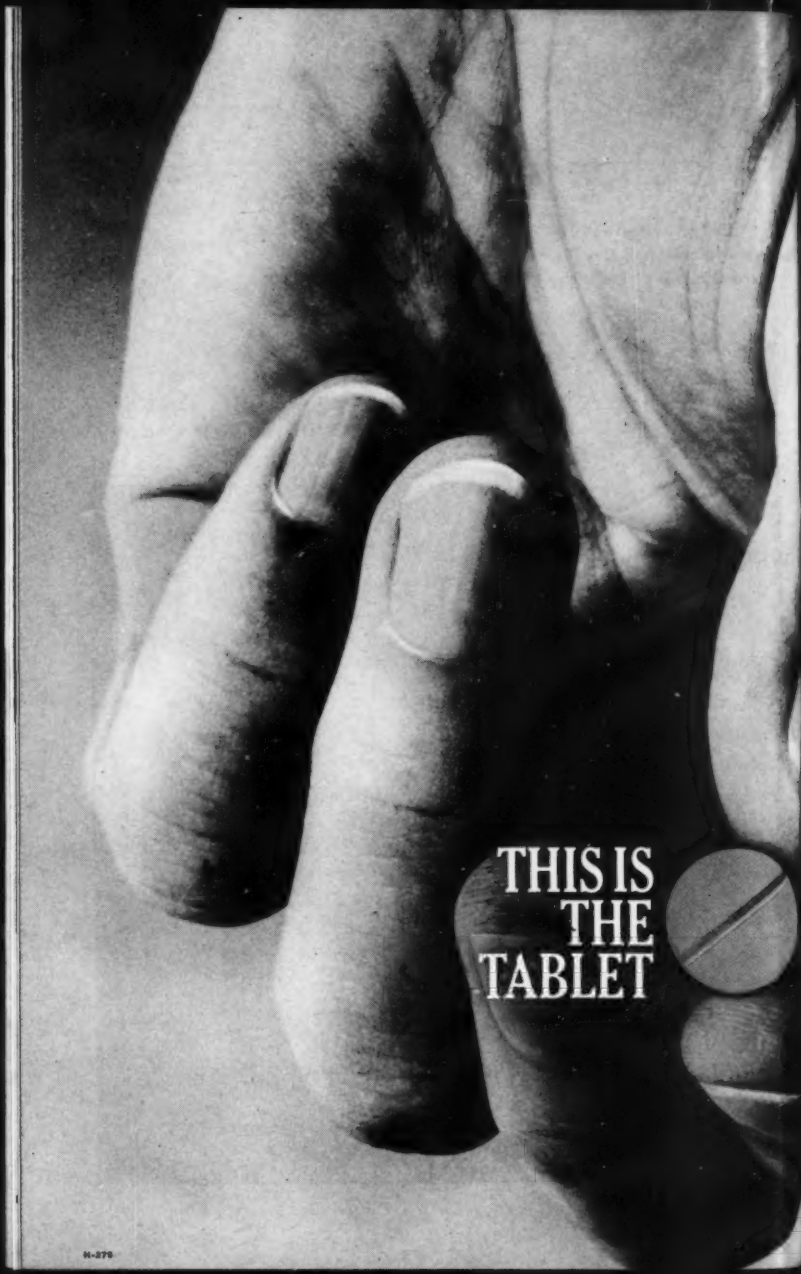
Chief Complaints: Mid-epigastric pain radiating towards the right and posteriorly for one day. Nausea and vomiting.



Which is your diagnosis?

1. Small bowel obstruction
2. Gallstone ileus
3. Emphysematous cholecystitis
4. Cholecystoduodenal fistula

(Answer on page 168)



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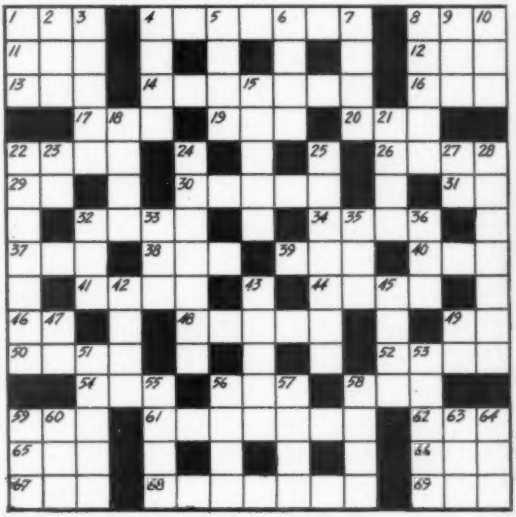
Resident Relaxer

(Solution on page 168)



ACROSS

1. Sick
4. Glucophospholipin found in the liver, spleen, muscles, blood and brain
8. In the past
11. In dentistry, a cast of the mouth over which is made the blank of artificial denture.
12. New (prefix)
13. Abbr. for electro-encephalogram
14. A furrow, fold, or crease in the skin
16. Number of digits on hands of a normal person
17. An exclamation of delight or regret (Pl.)
19. Lixivium
20. A wreath
22. Festive
26. Abbr. for adrenocorti-cotrophic hormone
29. Before meals
30. Large pelvic bone
31. In proximity to
32. Popular inlay material (Dent.)
34. Olfactory organ
37. Visual organ
38. A suffix denoting that the element to the name of which it is attached is in combination in one of its lower valencies
39. A liquid of fatty consistency and unctuous feel
40. Phenol source
41. A combining form meaning the back
44. A combining form noting defect of eye
46. Gr. ouron (urine)
48. Bone healing
49. Actinon (Chem. Symb.)
50. A prefix denoting half or partly
52. To stare or eye amorously
54. Auditory organ
56. U. N.'s Health Organization (Abbr.)
58. Basal nomina anatomica (Abbr.)
59. A London surgeon noted for an operation overcoming fresh adhesions in the joints
61. Tube leading from the bladder
62. The lower extremity
65. The singular of reis
66. Pinna
67. American Dietetic Association
68. A nutritional disease of young birds
69. Upper limb

DOWN

1. A suffix denoting a binary chemical compound
2. To assume a position of rest
3. German physician associated with cephalaglia pharyngotympanica
4. Maxilla and mandible
5. Structure consisting of series of windings
6. Type of retractor of the eye
7. Belgian physiologist and otologist (1847-1920)
8. Ludicrous act
9. "To the right"
10. An egg, the seed of a plant
15. A prickiny, puncture
18. An areola
21. Organs of hearing
22. Pertaining to most rarified state of matter
23. Anodal closure (Abbr.)
24. Of two days duration
25. The membrane around the fetus (Pl.)
27. Abbr. of tubercle bacillus
28. The fundamental unit of water
32. Substance that produces, or generates
33. Fortune
35. Abbr. for occipitolaevo-posterior
36. A Greek letter
42. Denoting a kind of defect of the eye (Comb. Form)
43. Vision
45. Hematopoietic essential
47. Abbr. for right eye
49. Aluminum (Symb.)
51. The middle coat of an artery
53. Fascia over the skull
55. The gluteal region
56. A N. Y. surgeon associated with appendicostomy
57. Unit of electrical resistance (Pl.)
58. Pouch or sac (Pl.)
60. One of the primary colors
63. Organ of hearing
64. Abbr. for gram

Letters to the Editor

Unsigned letters will neither be published nor read. However, at your request, your name will be withheld.

Foreign MD Concerned

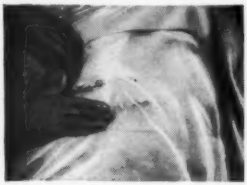
The following are excerpts from but one of many letters received by the editors concerning the spate of articles about foreign medical graduates in the U.S., which have appeared in lay and medical publications in the past few months.

Lately, there have been several articles in medical journals, magazines and newspapers, adverse to the reputation and pride of foreign doctors who are currently serving their internships and residencies in U. S. hospitals. We are deeply concerned and hurt about these derogatory statements. While some of these assertions might be true, others are plainly unfounded and discriminatory in nature. These are aimed at all foreign medical graduates, which naturally kindles a common voice of protest in our midst, irrespective of nationality or the medical school we came from. We feel that these slighting remarks not only affect us and our schools but also the respective countries from which we hail.

Firstly, the foreign doctors' knowledge of English is under question and criticism. Yes, this is an admitted fact. Is it not what might be expected from foreign doctors educated in Spanish, French, Italian, etc., and who have not used English, written or spoken in all his life? But surely if the blame is to be placed on anyone regarding the inability of some of us to speak or under-

—Continued on page 38

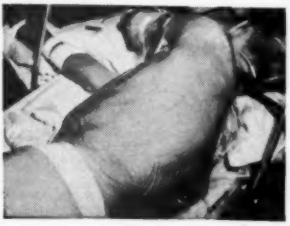
Basic technic When freshly "prepped" skin is dry, Vi-Hesive Adherant is sprayed on to an even pink tint from about 12" distance. Sterilized Vi-Drape Film is held taut over proposed operative area then smoothly molded by hand to site and wide adjacent skin area. Photo courtesy Ralph Adams, M.D.



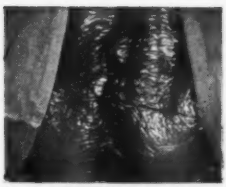
Sealing off the contaminated colostomy or ileostomy, and yet having it visible while exploring a new operative field, is made possible by the application of Vi-Drape Film to the entire area. Photo courtesy of Robert M. Zollinger, M. D., William G. Pace, M. D. and Marjorie J. Reed, R. N., Columbus, Ohio.

Visibility of landmarks, maintenance of asepsis in operative areas previously hard-to-drape, and isolation of the entire operative zone are particular surgical advantages of using Vi-Drape Film in neurosurgery. Illustrative is the isolation of the cervical occipital area for laminectomy shown above. Photo courtesy Arthur B. Eisenbrey, M. D., Detroit, Mich.

Smooth molding and close adherence of the plastic film to the difficult contour of the hip, provides an aseptic operative area previously considered almost impossible to achieve. Vi-Drape Film clings closely to the skin throughout long procedures. Photo courtesy Chas. G. Lovingood, M. D., Frank L. Shively, Jr., M. D. and Albert M. Storrs, M. D., Dayton, Ohio.



Large areas can be sealed off for thoracic or cardiovascular surgery without hiding landmarks. Neck and shoulders are completely isolated from the incision. A cleaner, drier operative field is possible using Vi-Drape Film. When Aeroplast Surgical Dressing is used postoperatively, evaluation of healing can be made without removing dressings. Photo courtesy Curtis P. Artz, M.D., Jackson, Miss.



Isolation of the anal area from the vaginal orifice during correction of prolapse of the vaginal vault avoids contamination by fecal extrusions.

Exteriorized vaginal vault is protected from contamination by Vi-Drape Film clinging closely to vaginal orifice during procedure and by isolation of the anus. Photos courtesy C. Paul Hodgkinson, M. D., Detroit, Mich.

To prevent trauma, desiccation and infection — Vi-Drape Film is frequently used as a protective wrap for exposed organs as shown above holding intestines during an aortic graft. Photo courtesy Chas. G. Lovingood, M. D., Frank L. Shively, Jr., M. D. and Albert M. Storrs, M. D., Dayton, Ohio

Would you like to see a full-color sound motion picture further illustrating the application of Vi-Drape Film in varied surgical procedures? The film, "A New Transparent Plastic Surgical Drape," produced by Robert M. Zollinger, M.D., William G. Pace, M.D. and Marjorie J. Reed, R.N., at Ohio State University Department of Surgery, is available for showing to all members of the surgical team.

Please send requests to:
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Station A—Box 1, Dayton 3, Ohio

Vi-Drape® Film, Vi-Hesive® Adherant-Pats. Pend.
Aeroplast® Dressing-U.S. Pat. No. 2,804,073

All photos shown are of actual procedures.

—*Continued from page 33*

stand English, it should be the U. S. Embassies in our countries. Before we can depart from our homeland and before our visas are approved, we are interviewed at the Embassy, one object of which is to determine our mastery of the English language.

The disparaging remarks about the lack of medical knowledge among foreign physicians is largely a misconception. This arises primarily from our inability to express ourselves adequately, using English as the medium of expressing our points of view. This does not necessarily mean the lack of the basic medical knowledge required to make one a physician.

There was a comment in one lay article that foreign doctors come to the United States without ever having examined a patient or listened to a heart. Everyone who has gone to medical school knows how absurd this statement is. In the Philippines for example, a medical student starts to do histories and physicals as early as his second year medical schooling. I am sure this also holds true in the medical education curriculum of other countries. It is true that some doctors come here immediately after their graduation, but even then, they have worked-up and cared for patients during their student days. Also, some of us, although coming as resident physicians, have been in practice as surgeons, internists, general practitioners, pediatricians, etc., for many years.

The general rule that the darker side of most things is more apt to be exaggerated and overemphasized than the brighter side, seems to hold true in this issue. Some people just do not seem to realize that our stay here is truly a sacrifice on our part. Some just plainly seem to overlook the good things some of the foreign physicians have done or at least contributed to the welfare of the sick. They don't seem to appreciate how a lot of those whom they call "inadequates" or "unfits" are trying their best in spite of handicaps and shortcomings which are not alone the fault of the foreign doctors. We are not begging for mercy or sympathy. What we are most concerned about is the gravity and the dire consequences that these unfair and outrageous statements against us will produce.

We are all aware that our stand regarding this issue and our fate as house physicians in U. S. hospitals is uncertain. Uncertain, be-

—*Continued on page 44*

"...sounding board of the emotions."[1]

Emotionally-induced or emotionally-aggravated gastrointestinal diseases, including peptic ulcer, often become quiescent with the adjunctive use of EQUANIL.

Bodi[2] and his associates found that meprobamate (EQUANIL) relieved tension and anxiety, yet did not significantly affect gastric secretory patterns. Calming was achieved without mental confusion.

Hundreds of published papers on EQUANIL attest to its high index of safety; predictable action; freedom from ataxic or extrapyramidal side-effects; lack of cumulative effects.

Although rare, allergic reactions may occur; dosage and quantity prescribed for all patients should be carefully supervised. For further information on prescribing and administering EQUANIL see descriptive literature, available on request. *Wyeth Laboratories Philadelphia 1, Pa.*

1. Weiss, E., and English, O.S.: Psychosomatic Medicine, p. 254, W.B. Saunders Company, Philadelphia, 1957. 2. Bodi, T., et al.: Am. J. Gastroent. 29:643 (June) 1958.

Equanil®
Meprobamate, Wyeth

ANNIVERSARY 1931 1956 Wyeth
A Century of Service to Medicine

—*Continued from page 38*

cause the tide is turning against us. Everything rests upon the decision of the medical authorities in whose hands is suspended the balance that will determine the future in our pursuit of medical training and of those future foreign physicians to come.

ROBERTO L. TAN, JR., M.D.
SIBLEY MEMORIAL HOSPITAL
WASHINGTON, D.C.

Loan on Insurance

In the near future I will need a sizable (at least to me) amount of money. I am wondering whether to try to get a loan or to cash in my permanent plan GI life insurance. Do you have any reprints or articles dealing with the situation — or can you advise me in any way. Thanks for your help.

NAME WITHHELD
AT WRITER'S REQUEST

• *If you cannot get a regular bank loan, then borrow on your insurance. The VA strongly advises not to cash in your permanent plan GI insurance. Reason: all protection ceases when the policy is surrendered for cash, and once cancelled, it cannot be restored. So you would be much better off borrowing on your insurance. "Paid up policyholders may borrow as much as 94 percent of the policy's cash surrender value," according to the VA.*

. . . In a Nutshell

I have just finished reading Mr. Kuchinsky's excellent article "Your Hospital Library" in the February RESIDENT PHYSICIAN. That is certainly putting library practice in a nut-shell! Your statement about having journals bound at a cost of $2.75-$3.50 per buckram volume interests me greatly. For the last few years our binding has been done at one of the state hospitals as an industrial therapy program but that has ended for the time being and I am trying to find a binder where we can have our journals bound at a reasonable rate. So far the quotations I have received have been exorbitant. I would greatly appreciate receiving the name of your binder.

With many thanks.

(MRS.) LORETTA F. SMITH
LIBRARIAN
Massachusetts Mental Health Center, Boston, Mass.

• *A list of approved binders is available at no charge from the Library Binding Institute, 10 State Street, Boston 9, Mass.*

—*Concluded on page 48*

when diapers and drops are discarded it's time to change to Vi-Sol™ chewable tablets or teaspoon vitamins

Vi-Sol chewable tablets and teaspoon vitamins, specifically formulated for the child over two, are the logical continuation of vitamin supplementation at the end of the "baby" period. The taste will show in their smiles.

DECA-VI-SOL,® 10 significant vitamins, **POLY-VI-SOL,®** 6 essential vitamins. **Chewable tablets,** with fruit-like flavors, dissolve easily in the mouth...no swallowing problem... no vitamin aftertaste or odor. **Teaspoon vitamins,** orange-flavored liquid vitamins that children take readily.

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Symbol of service in medicine
EVANSVILLE 21, INDIANA

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—Concluded from page 44

Korean Interest

Respectfully I appreciate the enormous activities of RESIDENT PHYSICIAN in the U.S.A.

I am on the staff (surgery) at the Seoul National University Hospital, Korea, and had been trained at the Department of Surgery, University of Minnesota Hospitals, mainly at Dr. Varco's (since 1957) until I left there last year, during which time I also much enjoyed RESIDENT PHYSICIAN.

I feel strongly that the RESIDENT PHYSICIAN will be instructive for Korean doctors as well as for those in the U.S.A.

I am sorry, however, that we do not have any means of getting the magazine directly from the U.S., because the way of remittance has not yet opened between the two countries.

Would you kindly try to find some way to let me get it regularly and continuously even when you do not have a formal regulation for a foreign country?

JA HOON KIM, M.D.
ASSOCIATE PROFESSOR
DEPARTMENT OF SURGERY
SEOUL NATIONAL
UNIVERSITY HOSPITAL
SEOUL, KOREA

• *We are sorry, too. Our circulation is limited to interns and residents in AMA-approved programs — plus chiefs and clinical professors in these programs. However, we will send you a copy each month for your medical library on a complimentary basis, beginning with the current issue.*

M.D.'s Social Security

There's been much talk about social security for physicians in recent months (I'm for it!) but I haven't learned of any definite action by our government regarding it. What's the present status? (P.S. I want to thank you for sending RESIDENT PHYSICIAN to me on a regular basis. Each issue has something of real value to residents — and I congratulate you for knowing what residents are interested in.)

ROBERT L. KELLER, M.D.
PHILADELPHIA, PA.

• *As this issue of Resident goes to press, the House Ways and Means Committee has given an informal OK to a change in social security regulations approving coverage for M.D.'s. The Administration is for it, too. Perhaps, by the time this copy of RP reaches you, the Committee may have issued a formal report.*

Perrin H. Long, M.D.

Editor's Page

ON THE QUANTITY AND QUALITY OF LIFE

II Moral, Religious, National, and Legal Responsibilities of Physicians in the Care of the Incurably Ill or the Dying.

Before discussing possible solutions of the problem which will increasingly confront us, the moral, religious, and legal concepts concerned with the medical care of the dying, or of the hopelessly ill must be explored. That man should have a surcease from suffering was early proposed by Sir Thomas Moore (a noted Catholic) who wrote in the second book of *Utopia:* "When any is taken with a torturing, lingering pain, so that there is no hope either of cure or care, the priests and magistrates come and exhort them, that, since they are now unable to go on with the business of life, are become a burden to themselves and all about them, and they should really outlived themselves, they should no longer nourish such a rooted distemper, but choose rather to die since they cannot live but in much misery."[1]

Francis Bacon in the *New Atlantis,* discussing the position of the physician when faced with the problem of the care of the hopelessly ill, said: "I esteem it, the office of the

physician, not only to restore the health, but to mitigate the pain and dolorours; and not only when such mitigation may conduce to recovery, but when it may serve to make a fair and easy passage."[1]

In one of the most penetrating and fascinating discussions of problems concerned with the medical care of the hopelessly ill or the dying, Glanville Williams, the noted English barrister and scholar, wrote in *The Sanctity of Life and the Criminal Law:* "If it is true that euthanasia can be condemned only according to a religious opinion, this should be sufficient at the present day to remove the prohibition from the criminal law. The prohibition imposed by a religious belief should not be applied by law to those who do not share the belief, where this is not required for the worldly welfare of society generally. But, further, the ancient opinion that religion requires resignation, that the more unpleasant of two alternatives has some intrinsic moral superiority, has lost nearly all its support. *At the present day it seems self-evident to most of us that laughter is better than sorrow, oblivion better than the endurance of purposeless pain.*"[1] [Italics mine, Ed.]

As physicians, one of our major concerns must be the resolution in our thinking of the meaning of that part of our Hippocratic Oath which reads: "Never will I give a deadly drug, not even if I am asked for one, nor will I give any advice tending in that direction." Now obviously, we as modern physicians do not interpret this literally. The alkaloids of digitalis are among the deadliest of drugs which the physician has at his command. A very few milligrams of a certain digitalis alkaloid taken by mouth will kill as certainly as does cyanide of potassium. Still thousands of refillable prescriptions are written for the digitalis alkaloids daily.

1. Williams, G. The Sanctity of Life and the Criminal Law, Alfred Knopf, New York, 1957, P. 349-350.

What then is meant by this Hippocratic injunction? Ludwig Edelstein of Hopkins, in his excellent study of the Hippocratic Oath[2] believes that as euthanasia "was an everyday reality" in the period in which the Oath was being formulated that this portion of it was directed against this practice. He further indicates that the Pythagorean Doctrines, alone in the content of Greek thought at that time, rejected suicide unconditionally. However another eminent student of the Oath, K. Deichgraeber[3] considered the injunction against poison to refer to murder by poisoning, an art not uncommon in those times.

As so frequently happens when a discussion of a moral issue is attempted, different interpretations emanate from equally distinguished sources. It should be noted however, that a little later, Plato[4] was of the opinion that invalids should not be kept alive. However there is evidence that his opinion was based less on suffering than on the social and economic burden which arises from invalidism. At about this same period, the Jews in the development of their moral philosophy had arrived at the concept embodied in the Fifth Commandment, "Thou shalt not kill." This subsequently, in about the Fourth Century A.D., was the basis for St. Augustine's pronouncement against euthanasia, and for all Christian opposition to this practice from that time on. As late as 1940, the Roman Holy Office condemned all direct euthanasia as a breach of the "natural and divine positive law."

What must be remembered at this point, is that there is no unanimity of opinion as to what was meant by the Fifth Commandment when it was enunciated. Our Old Testament

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2. Edelstein, L., Suppl. Bull. History of Med., P. 10, 1943.

3. Deichgraeber, K., Quellen Z. gerichte der Naturwissenschaft und Medizin III., P. 36, 1932.

4. Plato, Republic, III, 405, and V, 459.

has passed through many hands and many interpreters since it was first reduced to the written word by Jewish scribes. For example, there is a considerable body of opinion which holds that this Commandment should read, "Thou shalt do no murder" as it appears in the Book of Common Prayer. Were this agreeable to all, then one would really have to stretch the imagination to define euthanasia in current terms. Furthermore, as Fletcher points out, the Hebrew of the Decalogue "clearly means unlawful killing, treacherously, for private vendetta or for gain."[5]

A very complete discussion of the Catholic point of view on euthanasia is given by The Reverend Joseph V. Sullivan in his *Catholic Teaching On the Morality of Euthanasia,* published in Washington, D. C., 1954.[6] In essence, Father Sullivan believes that as the supreme control of life rests in the hands of God and God alone, under no conditions is it lawful for man acting on his own authority to kill directly an innocent person. Father Sullivan does however support capital punishment and the mass slaughter of the combatants of any nation which is *not* (in the opinion of its enemy or others) waging a "just" war. Individuals so involved cannot be classed as "innocent" in his thinking. Furthermore, in his discussion of the problem, he invokes the "wedge principle" which denies the possibility of considering the individual circumstances in applying rules. Father Sullivan has said, "The wedge principle means that an act which if raised to a general line of conduct would injure humanity, is wrong even in the individual case." It might be remarked that the employment of the doctrine of the "wedge principle" has characterized the writings of Catholic moralists on a number of the ethical and moral practices concerning which the practicing physician repeatedly has to advise his patients.

5. Fletcher, J., Morals and Medicine, P. 196, Princeton, N. J., '54.
6. Sullivan, J. V., Catholic Teaching on the Morality of Euthanasia, Washington, D. C., 1954.

Furthermore, it must be understood that in this presentation of views, certain Catholic authors have included more than positive action in defining euthanasia, and have broadened its meaning as is expressed in "Directive 22",[7] to include the following: "the failure to supply ordinary means of life, is equivalent to euthanasia." The injunction directive immediately poses the question as to the definition of the term "ordinary." Father Gerald Kelly, S. J.[7] writes *"ordinary* means of preserving life are all medicines, treatments and operations which offer a reasonable hope of benefit for the patient and which can be obtained and used without excessive expense, pain or inconvenience." He next defines *extraordinary means* of preserving life as the use of "all medicines, treatments, and operations, which cannot be obtained or used without excessive expense, pain, or other inconvenience, or which if used would not offer a reasonable hope of benefit."

These definitions and their wording raise several questions. First of all, what is "reasonable?" Father Kelly makes no attempt to define "reasonable," so turning to Webster's we find that "reasonable" is: "1. Having the faculty of reason; rational. 2. Just; fair-minded; of acts, thoughts; agreeable to reason, not beyond the bounds of reason. 3. Inexpensive, moderately priced." So we can say that "reasonable" is probably synonymous with "fair" or "moderate." It obviously does not mean "good" and certainly not "poor" as far as prognosis is concerned.

Now certain of Father Kelly's concepts relative to "ordinary" and "extraordinary" deserve much thought, especially by non-Catholic physicians. Father Kelly's point of view is that everyone "has the obligation to take the ordinary means of preserving life." This means also, he writes, that *"every patient has the duty to submit to any treatment which is*

7. Kelly, S. J., G. Medico-Moral Problems, Catholic Hospital Association, P. 128.

clearly an ordinary means." [Italics mine. Ed.] As the directive "is enunciating only a minimum: this at least must be done for every patient." An "outstanding theologian" quoted by Father Kelly said that ordinary means would include "the medicines, nursing, etc., usually adopted by persons of the same condition of life as the patient." In thinking of "ordinary" and "extraordinary means" the physician must be aware that there is "a clear distinction between the duty of *avoiding* evil and the duty of *doing good."* Evil must be avoided "at all costs," but there are "proportionate limits to the duty of doing good." One does not have to go to inordinate lengths in doing good. In terms of the patient, if the exertion involved in doing good is excessive then it becomes "extraordinary." In the same way, if the inconvenience involved in preserving life as far as expense, pain or other hardships are concerned, then the means of preserving life become extraordinary.

Another point made by Fr. Kelly is that "a medicine, treatment, etc., is to be considered an ordinary means, if it can be obtained, and used, with *relative convenience,* and if it offers reasonable hope of benefit." However it is important to remember that Fr. Kelly goes on to say "when either of these conditions is lacking, *the means is extraordinary"* [Italics mine. Ed.]. In the question of "duty," the obligations of physician and patient differ. The patient must always use ordinary means, the doctor (the medical team) however "must do not only what the patient is obliged to do, but also what the patient reasonably wants, and what the recognized standards of the medical profession require."

The question is then raised, "How is the doctor to judge whether he is obliged to use *extraordinary* means?" First, *"the wishes of the patients* should be ascertained," but it must be remembered that the patient has the moral right to refuse "the extraordinary means." When the patient cannot make this decision because of his condition, the family's

desires must prevail, as they represent the patient; if the family is not available, or cannot express a desire, or ask the physician to make the decision, then Fr. Kelly writes that the physician should "try to make a prudent estimate of what the patient would reasonably want if he could be asked. If means are lacking to determine this then the Golden Rule may be invoked. What would the doctor himself want if he were in the patient's condition?"

Of course in all of these determinations by the doctor, his decisions are influenced by his understanding of and practice of professional standards. Father Kelly states that he has "observed two different professional standards in this matter." Some doctors believe that no matter how hopeless the situation, any and all means should be used to prolong life until its last flicker. If one does this, the question of euthanasia never enters the doctor's mind, and any feeling of defeatism is completely avoided. This standard may also be easiest on the doctor's conscience. *He also avoids having to make any decisions which may be disturbing to him.* In other words he takes the easiest way. On the other hand, many very fine doctors take a different stand, and as Father Kelly puts it, *"these doctors try to effect a cure as long as there is any reasonable hope of doing so; they try to preserve life as long as the patient himself can reap any tangible benefits from the prolongation."* [Italics mine. Ed.] These doctors "think there is a point when such efforts become futile gestures; and they believe at this point the sole duty of the doctor is to see that the patient gets good nursing care and that his pain is alleviated."

Father Kelly in comparing the "strict" and "moderate" standards which have just been described writes of the moderate standard "it seems to be very much in accord with the traditional policy of Catholic theologians of interpreting obligations according to a reasonable limit." Furthermore it is believed that the moderate standard "seems to

square with a good Christian attitude . . . Finally, it seems that the moderate standard is least likely to impose excessive burdens on the patient's relatives. Relatives often endure terrific strain and undergo great expense while life is being prolonged by artificial means; and in some cases, e.g., terminal coma, very little good seems to ensue. The moderate standard spares them some of the strain and expense."

In contradistinction to the Catholic exposition of this problem, Protestant thought and discussion has been relatively limited. As far as most liberal Protestant sects are concerned there are no firm pronouncements. Even such an authority on Protestant morals as the Archbishop of Canterbury in 1936 admitted "that cases arise in which some means of shortening life may be justified."[8] He feels that this determination should be adverted to the medical profession. As pointed out by Rabbi Dr. Immanuel Jakobovitz in *Jewish Medical Ethics*:[9] "The predominantly 'this-worldly' character of Judaism is reflected in the relative sparsity of its regulations on the inevitable passage of man from life to death. The rabbis, as we have noted, place a severely practical emphasis on the axiom that the ordinances of God exist so that man 'shall live by them,' (Lev. XVIII, 5)." However, as Dr. Jakobovits states relative to the care of the incurably ill or the dying, "any form of *active euthanasia* is strictly prohibited . . . At the same time, Jewish law sanctions and perhaps even demands, the withdrawal of any factor—whether extraneous to the patient himself or not—which may artificially delay his demise in the final phase. It might be argued that this modification implies the legality of expediting the death of the incurable patient in acute agony by withholding from him such medicaments as to sustain his continued life by unnatural means . . . it is therefore not

8. Parliamentary Debater (House of Lords), Vol. 169, Cols. 562-3.
9. Jewish Medical Ethics, N. Y., N. Y. Philosophical Library.

altogether clear whether they would tolerate this moderate form of euthanasia, though that cannot be ruled out." Rabbi Jakobovits goes on to say that "Jewish teachers were not out of sympathy with every effort to deliver incurables from their agony and cites *RaN, Nedarum 40a, Kethuboth 104a, b Baba Metzia,* etc., and *Yakut, Proverbs* No. 943 as authorities for his statement.

Aside from the religious aspects of the care of the incurably ill or the dying, another and most interesting factor has been injected into our ethical concepts concerning this problem by agencies of our government during the past few years. This has to do with the complete about face in policy, relative to the care of casualties resulting from a nuclear attack on this country. The current policy is to treat definitively the lightly injured *first* and the surviving seriously injured *last,* which means of course that there would be few seriously injured survivors after an attack. This is exactly the opposite point of view which had been held relative to the treatment of casualties in all previous wars in which our country had been engaged. The extraordinary fact is that this new policy has been accepted by the medical profession of this country without dissent or even much discussion. Its implications were too self-evident.

As Williams points out,[10] "Under the present law, voluntary euthanasia would, except in certain various circumstances, be regarded as suicide in the patient who consents, and murder in the doctor who administers." In England and America there are no records of a conviction, with one record of a prosecution in the United States, and one in England.

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10. Williams, G., Ibid., 318-26.

Perrin H. Long,

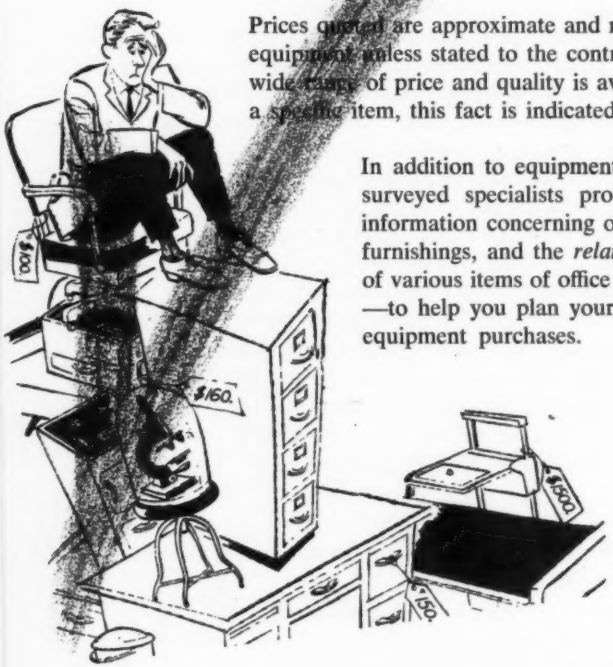
Resident Physician reports on . . .

Office equipment you'll need in your beginning private practice

Here is the first in a series of exclusive articles on equipping your office for the private practice of your specialty. Recommendations are based on a survey conducted by your journal among practicing specialists.

Prices quoted are approximate and represent new equipment unless stated to the contrary. When a wide range of price and quality is available for a specific item, this fact is indicated.

In addition to equipment items, the surveyed specialists provided important information concerning office layout, furnishings, and the *relative importance* of various items of office equipment —to help you plan your future equipment purchases.



Equipping

It's not too early to start planning your choice of office equipment. Practicing pediatricians offer some practical advice on what is actually needed on the first day in your practice and what items might better be postponed.

. . . the Pediatric Office

The pediatric office is unique in at least one important respect. Since the pediatrician in private practice deals with two parties, the child patient, and the parent who accompanies the child, the pediatric office is designed and equipped to accommodate both. And in most offices of the pediatricians in our survey, this was translated into a compromise between living room comfort and playroom utility.

Waiting room

In planning your waiting room, keep this advice in mind, as offered by pediatricians surveyed: The waiting room should be functional, not luxurious. Frills, furbelows and fussy decorations are out, though your inclination (and your wife's) may be to jazz up the decor as a delight to youngsters.

First of all, carpeting is neither necessary nor desirable. Consider a rainy day, 14 children with muddy feet, and the impracticability of carpeting becomes obvious. Also, carpets are not cheap—to buy or to keep clean.

According to the great majority of practicing pediatricians in our survey, a colorful composition tile or linoleum on the waiting room floor looks fine, stands continued abuse, and is relatively easy to maintain. And too, there is an unlimited variety of tasteful nursery designs and circus type prints to choose from at prices which won't crack your limited budget.

A waiting room of average dimensions can be covered with

an attractive tile or linoleum for less than $100, compared to carpeting costs of nearly three times that amount.

For a pleasing accent on the tiled floor, washable, *nonskid* throw rugs fill the bill perfectly, report pediatricians in our survey.

Strong chairs

As with other office fixtures, the pediatric waiting room furniture must take into consideration use by adults and children. Chairs for the parents and smaller chairs for children can be comfortable but must be *strong*.

Safety of course is an important factor. Sturdy chairs that won't tip over easily, and having smooth arms and legs without projecting decorations, are important.

Plastic-covered wooden chairs are a good choice. These are comfortable, come in attractive colors and are washable. They can be purchased as separate units, with or without arms, or in units of two or three matching pieces to make a functional couch arrangement. Chairs of this type cost from $25 to $40 each.

Since the average waiting room of the pediatricians in our survey listed chairs for six adults, you should allow for about three or four to start, at about $35-$45 each.

Children's chairs are smaller and cheaper. You can get them as rocking chairs or folding stools (not recommended), or low, sturdy chairs or benches (good). Prices run from $8 to $20. Though surveyed pediatricians agree you should have as many juvenile chairs in the waiting room as there are chairs for adults, most didn't have this many. Obviously, if space or money is short, buy only adult chairs—children can sit on chairs large or small, grown ups can't.

Magazines, tables

The pediatrician's office will have magazines for parents and magazines for children. By placing adult magazines on wall racks above the children's reach, many pediatricians get better mileage from these periodicals.

Wall racks can easily be built by you or a local carpenter for less than $25. Manufactured racks are slightly more expensive.

Children's magazines should be placed on a low level so the child won't have to annoy his parents each time he wants another magazine. Locate them in play boxes along a wall or in low, sturdy magazine tables. Simple tables can be purchased

for $20 to $40 each. Unpainted tables are quite a bit cheaper and can be painted bright colors by you or your wife.

Lamps

Floor lamps and children don't mix. Table lamps are easily toppled. A good suggestion is to have most of the lighting from ceiling or wall fixtures. These lights can be attractive, inexpensive, provide good reading light, and more important, they can't be tipped or broken easily. Prices vary considerably. But good looking lamps for wall use can be purchased for $15 to $25.

If you must have table lamps, keep them safe and simple. There should be no unnecessary glass to break and cause injury to your patients. Ornate lamp shades add little to the room except disorder and extra dust to bother allergic patients.

Play area

Most pediatricians recommend a special play area for children in the waiting room. This can be arranged so as to keep children out of the parent's way and at the same time give the children some occupation while they are waiting. A corner of the main waiting room equipped with a play box and toys is adequate. A small room off the main waiting room is better.

Expense can be kept down by the purchase of a children's play box for $10-$20 and another $15 for a few toys.

Toys, of course, should be purchased with safety in mind. Riding toys that may collapse and injure the child should be avoided. Also, stay clear of toys with many small parts or sharp edges. The best and cheapest toys are washable plastic, stuffed animals; reading games, and draw-

TWO STEPS TO SAVINGS

1. Contact an office equipment company having an advisory staff and previous experience in equipping doctors' offices.

2. Make a tentative list of equipment items you think you'll need immediately—together with cost estimates.

ing books. Crayons are available that can easily be washed off walls and furniture.

Consultation room

The consultation room is where the physician and the parent discuss the child's illness. With infants and pre-schoolers, discussions are usually held in the examining room, after the examination has been completed. Economy often eliminates a separate consultation room, as such, in the beginning practice. The solution here is to combine it with the examining room.

A desk is required in the consultation room, according to survey respondents. Its size and style depends upon the space available. A good desk can be bought for $75 to $150. Plenty of drawer space will help accommodate records and literature, but most pediatricians in our survey indicated the importance of a filing cabinet.

Two or three chairs in this room will take care of you and your patient's parent(s).

Bookcases, chair

Give extra attention to your own chair. In all your years of practice this will be your closest companion. Good chairs are not "standard."

Don't buy from a catalogue or from a picture. Try it out first. Prices range from $50 to $100. Patient and parent chairs may be armless to save expense and can be purchased from $35-$50 each.

Bookcases are necessary. These can be functional as well as decorative. Wall bookcases save space, can be built by you or a carpenter. Incidentally, ask for "shelves" not "bookcase." When a "bookcase" is requested the price goes up. A good sized sample cabinet should also be considered.

If you have a separate consultation room you may consider carpeting this area. A carpet adds dignity and also tends to absorb sound so that your conversation won't carry to other areas of your office space. A good carpet with suitable backing can be purchased from $8 to $12 a square

yard, including installation.

Choose a desk lamp which reflects its light downward, away from your patient's eyes. Such a lamp can cost as little as $15, or as much as $50.

Examining tables

Unless you intend to limit your practice, the examining room should have two types of tables: a large table for older children and a smaller one for infants and newborn. Commercial tables can be purchased in a medical supply house for from $250 to $450.

The more elaborate and expensive tables have built-in scales and measuring devices. The new pediatrician might easily do without these deluxe models, according to our surveyed doctors.

A kitchen supply house will build a table to your directions and specifications for about $150. It can be brush-painted or sprayed in any desired color. The mat will be extra. A good adult examining table can be bought secondhand. (The pediatrician's table doesn't require drains, special cabinets for surgical instruments, or electrical outlets.)

You can have your secondhand equipment, including all cabinets, and examining room equipment, professionally spray-painted in a choice of colors for under $125.

Fluoroscope

As a rule, fluoroscopes are less expensive than x-ray equipment. In some locations, patients may feel that any good pediatrician will have facilities for fluoroscopic examinations. Fluoroscopes are either upright or horizontal. They are equally good. The type chosen pretty much depends upon the space available and the physician's past training.

Used fluoroscopes are available for $500 to $600, while a new one costs $1000 or more. While the fluoroscope will be guaranteed if bought in a reliable supply house, it is important to get a separate guarantee on the fluoroscopic tube.

A good apparatus to consider is a type of fluoroscope-x-ray arrangement that can double as an examining table. While the apparatus may be no more than 15 or 20 milliamps, this is usually sufficient for children.

The price of this triple purpose equipment is usually around $1200-$2000 new, $700-$1000 secondhand. Considering the price of an examining table by itself, this equipment can be a bargain.

The examining room also requires a refrigerator for the physician's antibiotics. There are many types but one should be

CONSULTATION

Though such things as decor, style and layout of an office are decided by the individual physician, you would be wise to consult an office equipment firm; many offer a free advisory service. Most firms and many banks provide an equipment loan and purchase plan which utilizes the equipment as collateral.

chosen with sufficient cubic feet of space. The price, if new, will vary from $125 to $175 for six cubic feet.

X-ray

The question of whether or not to purchase an x-ray or fluoroscope is an involved one. Pediatricians consulted disagreed on this point. An x-ray is expensive and even if purchased secondhand will easily cost $1200 or more. Then there's the expense of a special dark room and solutions which must be kept in decent condition.

In an active practice, with a large volume of patients, the return on your investment in an x-ray would probably be excellent. In the beginning practice, however, the call for x-rays is limited. The three or four x-rays needed in a busy month can easily be turned over to a radiologist. (Some you would refer even if you had your own.) Later, when the practice has grown, it may be wise to purchase an x-ray. If you can afford one now, well and good. But most new men can't.

Laboratory equipment

Every pediatrician should have facilities to do a complete blood count, a routine urinalysis, and a sedimentation rate. The equipment required needn't cost more than $75. A microscope can be purchased secondhand for about $150. The investment is small and the need is absolute.

More expensive equipment, required for detailed blood chemistries, is not needed for the first year. You will use a commercial laboratory for much of your work.

A good yardstick for your equipment budget is this: if an item will pay for itself in the near future, it is needed and well worth the expense; if it will take years to return the investment and is not needed urgently, then consider postponing its purchase.

A few surgical instruments are necessary. You will be able to do minor suturing in the office. Necessary instruments can be acquired for less than $100.

A sterilizer or an autoclave is necessary, of course. Get a good one. Electrical connections and instruments deteriorate with age and since a new sterilizer can be purchased for about $100, don't take a chance on a secondhand one.

An autoclave will run more, and for the beginning practice it wasn't considered a "first consideration investment" by our panel of practicing pediatricians.

Two scales are needed; one for infants and one for older children. A good infant (basket-type) scale costs $35 to $50. Standard (upright) scales can be purchased for under $75.

You will need at least two spotlights. The wall-mounted are handy yet out of the way when not needed. Each should cost from $25 to $50.

Printing

There are a number of incidental items which should be included in the office equipment budget. One of the most important of these, but often overlooked until the last minute, is "printing." This would include your announcements (to let the other doctors in your community know you're in business), personal cards, letterheads, billheads, case records, bookkeeping forms, etc.

The total expenditure you can expect to make for this type of necessary professional printing will be about $75. There are firms which make a specialty of supplying doctors' printing needs. Quite often it will save you time and money to order your forms, stationery, and a bookkeeping system from these specialists. In most cases, you can make all such arrangements by mail.

How much?

Many of the pediatricians questioned emphasized the need for making a list. They urge:

- Make it complete.

• Divide the medical from nonmedical equipment.

• Include every detail.

• Get price estimates, new and used. Put these in columns alongside each item.

• After you have your totals start checking back to see (1) what can be eliminated for now, and (2) what can be purchased for less, perhaps without "added" features for which you have no real need.

Quality cost

Quality is important. As a general rule, cut out the extra flounce items before you get cheaper items of *needed* equipment. This way, you will build a quality-equipped office as you go along. What you have will be good even though you won't have everything right from the start.

For an office of four rooms you can figure on a minimum of $2500, a maximum of about $6000.

Compare

One thing in which there was general agreement by pediatricians:

No matter how much you may have to spend, if you pick and choose carefully, comparing as you go, you'll get better value at less cost.

An outdoor vacation with pay?
Better get busy now . . .

Last Call for Summer Camp Jobs!

This summer, if you happen not to be rich enough to afford a luxury vacation, you might be thinking of earning a little something to help you get off to a better start in your practice or your next year of residency.

If that's your situation, take a look into summer camp openings for physicians.

Here's a golden opportunity to get paid a salary where there's little opportunity to spend it.

Perhaps you're right in the middle of your residency and have only a few weeks vacation coming. It can still work out. Many camps allow what they call a "split season," taking on one resident who guarantees them a replacement from among his colleagues to finish out the season. You can team up with another resident and stagger your vacation times to give full season coverage to one camp.

If you think a camp M.D. might be a good spot for you, get started now. Camps hire ahead of time; they're filling July through August positions.

Openings

Where to find openings:

- Your hospital's bulletin board. Most camps start sending out notices to hospitals in their areas about February.
- Your local medical society frequently will get requests for camp physicians. A telephone call to the society or a careful look-through of the classified section in the society's journal may turn up something.
- Established physician placement agencies in your area. Many camps list with the same agency year after year. The agency can help you evaluate the kind of set-up you will be getting into. Again, if you apply early, you'll get your pick of camps.
- The Sunday supplement and classified sections of metropolitan newspapers.
- National and "family" circulation magazines. While there won't be any ads for camp physicians, you will get a good supply of camp names and addresses; also, camp associations.

It may prove a good shortcut to write directly to the camp association headquarters requesting information about physician openings in any of their summer camps.

One big national group, the American Camping Association, maintains headquarters in Martinsville, Indiana and has regional or district offices located around the U.S. for placement of camp counselors, nurses, and physicians.

Brief

In your first letter to any camp inquiring about an opening, give a brief resume of your training, licenses if any, and the exact dates you will be available.

Also, request some screening information from the camp. For example, find out what period you will be required to serve and the probable salary.

This is one way to eliminate the negative. For instance, it's obvious that if the camp wants you to start before your residency is completed, it would be a waste of your time to continue the correspondence with this particular camp.

Since camps are having quite a bit of difficulty in getting doctors, you're in a shopper's market. Don't jump at the first salary offer (unless you are completely satisfied, of course). You will be

TEN QUESTIONS YOU SHOULD ASK ABOUT SUMMER CAMPS

1. LICENSE. Is a license needed in the state where the camp is located?

2. ASSISTANT. Will you have an assistant? Many camps will have a nurse on the payroll.

3. CONSULTATION. Are there hospital facilities in town? What arrangements has the camp made with the hospital? Is there a local physician available to help you when needed for consultation? Have arrangements been made for you to hospitalize a seriously ill child?

4. DISPENSARY. What are the facilities of the dispensary? How well is it equipped? Will your recommendations be accepted as to the needed supplies of the dispensary?

5. SPECIAL CARE. Must all children have physical examinations by their private physicians prior to their acceptance by the camp? Will the camp knowingly accept diabetics, allergic or cardiac children (requiring constant and specialized care)? If so, will you be responsible for their maintenance therapy and management?

6. COVER. Here are important items which should be settled in advance! What are your days off, if any? Will you have anyone to cover you?

7. WIFE. Are there facilities for your wife and family? By and large, camp directors consider the camp physician's wife a problem—unless she is willing to help out in some small way with the camp's activities. Camp directors will usually offer her some job as assistant to a counselor, arts and crafts supervision, picnic manager, or some such position—and are happy to pay her for her efforts.

8. SALARY. What is the exact salary? (Is there a contract?) Most camps figure your pay by the season, vary from $500 to $900 for a 7- to 10-week season.

9. DUTIES. Do you have any other duties besides strictly "professional care" of the campers and camp staff? Some camps try to have their physicians double as nature counselors or advisors.

10. MALPRACTICE. Are you covered by a malpractice policy? If not, will the camp pay for such a malpractice policy if you take one out for the duration of your camp job?

WANTED: PERSONALITY

What do summer camp directors expect of a physician? One expressed it this way: "First, I want a man who is professionally qualified. Training references help us determine this. Second, personality really counts. Most people think of summer camps as vacation playgrounds, baby sitters away from home. In part this is true. But more important, we think, is our educational responsibility, helping the child toward emotional maturity—teaching him to accept responsibility for himself and others. This is where the physician's personality comes in. If he is really interested in the children, he gives them confidence, guides them away from an over-concern about minor cuts or temporary malaise. In short, he helps them grow up. This doesn't require a grim scientist—simply an affable, outgoing human being who is competent and interested in the children under his care. We ask the same of our counselors: Competence, common sense, and interest in the children."

in a position to negotiate a bit. Perhaps you might suggest a higher figure and then work back to a compromise.

Or, if the camp is particularly desirable from your point of view, work on a few possible fringe benefits which have not been offered. Such things as your wife's job, or maintenance for your family, your days off, etc.

Value

Don't undervalue your own usefulness to the camp. You *may* have to work your head off throughout the summer — in which case, it would be nice to have something in the bank to show for your efforts.

Incidentally, many private camps will offer you more in salary than will some of the organization camps such as the Scouts, fraternal groups, etc. But there is no "standard" rate. Perhaps it should depend on the number of children involved and how much each child must pay to come to the camp — but it doesn't.

Try to arrange for such things as salary and time off and equipment *before you sign.*

If the job fits, take it. Summer camp can be a refreshing experience after a long year in your hospital.

NEWS ROUNDS

Three Year Registration

Maryland Law—Effective June 1, 1960, all physicians holding a Maryland license will have to reregister every three years. Physicians licensed to practice medicine and surgery in Maryland who do not receive a registration application from the Board of Examiners by September 1, 1960, should notify the Board. (1215 Cathedral Street, Baltimore 1, Md.)

Fewer Public Mental Patients

Decrease Shown for Fourth Straight Year—The USPHS' National Institute of Mental Health reports a slight (0.4%) decline in the number of resident patients in public mental hospitals in the U.S. for the fourth year in a row, reversing the upward trend prevailing since 1900. Admissions continue to increase but discharges outnumber them. Dr. Robert Felix, NIMH Director, said the figures "undoubtedly reflect a prevailing improvement in the care and treatment of the mentally ill both in and out of mental hospitals." No longer considered a custodial institution, he said, "the mental hospital's function, like other hospitals, is to rehabilitate the patient so that he can return to the community." Communities are assuming more responsibility, providing preventive and rehabilitative services that help keep people out of mental hospitals. Also credited were new and improved treatment methods, psychoactive drugs, increased use of psychiatric beds in general hospitals, outpatient clinics, nursing homes, and sheltered workshops.

SPECIAL REPORT

FROM THE FIFTY-SIXTH CONGRESS ON MEDICAL EDUCATION AND LICENSURE

The Role of Patient Care i Bas

In February, your Editor attended the Fifty-Sixth Annual Congress on Medical Education and Licensure sponsored by the American Medical Association, the Advisory Board for Medical Specialties, and the Federation of State Medical Boards. Here is a report on the three-day meeting.

The discussion in the symposium on "The Role of the Patient in Basic Medical Education" was opened by Dr. Leland S. McKittrick. He briefly considered whether the training of a house officer should be of the nature of a preceptorship, or an apprenticeship. He outlined the problem which faced the educator in graduate training programs in achieving a proper balance between providing adequate medical service for patients and an educational program for the house officer.

Dr. Arthur Richardson, professor of pharmacology, and dean of Emory University School of Medicine, spoke next on "Medical Service as a Medical School Function." He pointed out that there is a considerable dichotomy of philosophy and purpose in the undergraduate curriculum, in

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Basic Medical Education

Perrin H. Long, M.D.

what is trying to be achieved in the Basic Science courses and in the ward clerkship. Medical schools, whose functions were and primarily should be educational, got into problems of medical service when their students left the hard boards of the lecture halls and entered the wards. This resulted in the medical school, which initially was concerned with education and research, paying considerable attention to the quantity and quality of medical service provided by the ward clerks.

In Dean Richardson's opinion, too much attention is currently being paid by medical schools to medical service and research. More should be paid to education. He drew attention to the fact that in charity hospitals, as a rule, the medical schools had to assume responsibilities for the care of far more patients than were needed for teaching. However, this surplus of patients was frequently needed for the training of paramedical personnel.

Quality of care

The next paper, given by Dr. Edmund Pellegrino of the University of Kentucky School of Medicine, dealt with the "Care of the Patient in the Medical School Setting." He pointed out a truism which is sometimes forgotten, namely that the quality of patient care provided in a teaching service bears a very close relationship to the quality of teaching in the wards of that service. Furthermore, the level of care being

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The first part of this report appeared in Resident Physician last month.

given, and which is noted by the impressionable student, is naturally what he adopts as his own standard. The speaker also brought out that teachers were often too impersonal when dealing with service patients. He indicated that the presence of students on a ward and bedside teaching increase the problems of medical care and stresses undergone by patients. In his opinion, the best quality of care existed in those environments in which both teaching and research was being done. He stated that patients often go to teaching hospitals because they feel that the level of *technical* care will be better in such a hospital.

The point was stressed however, that one must avoid having two standards of medical care, one for private patients and the other for individuals on the ward service. He also felt that it would be wise for the student to gain experience in community medicine in addition to his ward clerkship.

Finally, he warned that something must be done to stem the deterioration in the ethical values held by doctors and medical students because, as he put it, today when the medical profession in this country is at the highest point of technical perfection in its history, it has declined to a relatively low ebb socially.

Curriculum

Dr. R. C. Dickson of the Dalhousie University Faculty of Medicine ventilated the subject, "The Patient, Physician-Teacher, and the Student." In essence he outlined the medical curriculum year by year as it exists in Dalhousie University, together with comment on the philosophy which governs the curriculum. One of the outstanding features of the curriculum he discussed is the use of, shall one say, apprentices (students), indentured to experienced older physicians who are assisted in their instruction of the student by enthusiastic juniors.

The way the time is arranged is such that it does not force the student, and permits ample time for reading and developing good reading habits, for the formation and use of discussion groups, and for the student to get over his awkwardness.

As he is not overburdened with patient service, the student has time to polish up his histories, check his physical examinations carefully, and has plenty of time for the synthesis of all facts relating to the patient's illness. It is not until his last year that the

student has his ward clerkship, and again he is apprenticed to a visiting physician who acts as his teaching tutor. At Dalhousie the bulk of the teaching in the clinical years is done by the voluntary faculty members.

Questionnaire

Next, Miss Helen Hofer Gee took up the subject of "Learning the Physician-Patient Relationship, Viewed in Retrospect by the 1950 Class." A questionnaire which had a good response from the Class of 1950 gave the following data:

- Respondents were asked where they thought their undergraduate education had been deficient. Some 30% indicated the area of application of Basic Sciences, 20% reported deficiencies in their clinical training, 42% stated there had been deficiencies relative to practical instruction in physician-patient relations, and 8% indicated that everything was fine in medical school.
- The second question had to do with whether the graduates felt that they had a need for a better understanding of doctor-patient relations when they went into practice. Answering in the affirmative were 50% of the general practitioners, 40% of the specialists, 30% of the part-time specialists, and 15% of the clinical teachers.
- The group was also asked how they rated the opportunities for learning about physician-patient relationships. Less than 50% rated medical school as a good place. Two-thirds rated the internship, and 83% rated the residency as providing the necessary opportunities.

Learning by doing, was favored over learning by observation, and the majority questioned were firm in the belief that an understanding of the facets of the doctor-patient relationship can only be obtained by close association with patients.

Hospital patient

The next speaker, Dr. Guy Hayes, discussed how "A Patient Looks at the Medical School Hospital," a subject to which not enough thought has been given. He stated that each patient on entering a hospital was unique in his reaction to his new environment. Fear, he believes, is a constant feeling in almost everyone who goes to a hospital. Because of this, from the very beginning all concerned with patient care must show that they possess the milk of human kindness.

He felt absolutely convinced

that patients receive better care in teaching hospitals, because the very presence of teaching keeps everyone on his toes.

Ward rounds

He raised the question as to whether there is room for improvement of the environment in teaching hospitals, and came to conclusion that there is. For one thing, the tenor of ward rounds might well be improved to make them less disturbing to the patients. Too often patients are embarrassed by what may be said or done, they get bits of information which they interpret wrongly, and the words "degenerative," "coronary," etc., as used, may be misinterpreted and produce severe anxiety. Myocardial infarction has been noted to occur immediately after ward rounds. The speaker made a plea that ward rounds be conducted so as to have a salutary effect on patients, by reducing tensions and worry. He felt that this can be done if there is better teamwork between the house staff and attendings. He felt that the attendings could be briefed on many factors relating to the patients, before the actual ward-walk begins. Discussion of social histories by and large should be held to a minimum before the patient or other patients. The pros and cons of various laboratory or clinical procedures should not be discussed.

A member of the house staff should return to the patient's bedside as soon as possible after a patient has been seen, in order that what has been said is translated, so that the patient has a proper understanding of what has gone on.

Consideration

Dr. Hayes pointed out that a proper balance must be struck between the teaching and service aspects of a hospital. Hospital routines should be studied, as they may be very distressing to some patients. Too many examinations by too many people may be very upsetting. The old saw, "Too many cooks spoil the broth," is often only too true. Blood letting by inexperienced leeches may be very disturbing. Careful consideration should be given the question of the necessity for every procedure which is done. Tests are costly, and anything done to a patient may scare him, hurt him, cause worry, or all three. Dr. Hayes thinks it would be a good thing if every doctor had all the procedures which he orders, done on himself. He feels that the flagrant use of tests is highly undesirable,

and that the physician of today does not learn to have a critical point of view, because so often, broad-sides of tests are fired at a patient, without thought being given as to what the specific target is. He closed by saying that the scientist must be a humanist and a humanitarian if he is going to succeed.

Provocative content

The final paper of the morning session presented by Leo N. Simmons, Ph.D., executive officer of the Institute of Research and Service in Nursing Education, Teachers College, Columbia University, was provocative and challenging in its content. Dr. Simmons first considered a number of current assumptions which he thought he could make relative to what patients think.

Modern medical and nursing skills can make, and have made, undreamed of contributions to the preservation of our health. People go to hospitals today to get well. They expect to.

Modern medical personnel are not utilizing their potentialities fully, because of faulty administrative organization, methods, and practices.

Patients are less and less satisfied with what they get in the way of medical care, and are worried because they believe things should be better. They are puzzled about motivation in respect to the hospital, research, education, costs, and service. [This is especially true on the part of major labor union officials today. Ed.]

For a number of reasons, some very ill-defined but having to do with the inward drives of patients and the environments in which medical care is given, *scientific medicine has to cope with serious subterfuges on the part of patients to avoid receiving all that modern medicine can offer them. At times patients are downright recalcitrant.*

Changes

Dr. Simmons then went on to point up a number of factors which are bringing about changes in the established patterns of medical care. First is the increasing physical and social mobility of our population. Secondly, patients are becoming much more sophisticated, and the omnipotency of the profession as a whole and the doctor as an individual is tending to disappear. Thirdly, the increasing commercialization of, and the outward evidences of the prosperity of the profession has had a deleterious effect on the doctor-patient relationship. Pa-

tients think more and more that doctors must be sharp business men, and as a result the profession is losing the halo which it has had in our country during the past century. Fourthly, there has been a marked change in the age composition and disease prevalence of our population. Major killing communicable diseases are under control, while illness in older people still presents a problem in medical care, because for management, it requires the control of the patient. Fifthly, medical care is being definitely affected by the materialistic attitude of the American people towards life, and the "me-to" philosophy that permeates our national structure.

Then too, one of the extraordinary developments of recent years is the tendency to organization. We are too organized today. We have gotten to the stage where we organize to cope with other organized groups.

Dr. Simmons then pointed out that one of the areas in which hospitals and medical personnel fall down badly today is in their care of the dying person. Too little thought is given to the problems of the individual who is in death's shadow and practically none to those of the relatives and friends of the dying patient.

Prepayment plans

Finally, Dr. Simmons discussed factors of the rapid growth of prepayment plans, both nongovernmental and governmental, which provide varying amounts of medical care. The goal of these plans is to improve patient care. For that reason the patient (the consumer) must be in on the planning and decision making about how he is going to be taken care of. Dr. Simmons' paper was met by loud applause. There could be no doubting that the audience was saying "Amen" to what he had just told them.

A GUIDE for our readers

The conventions of the presentation of advertising material on pharmaceuticals are related to certain ethical and practical considerations. This guide should be of help to all our readers in an understanding of the advertising material contained herein. Unless it is stated to the contrary:

All illustrations of physicians and patients are dramatizations utilizing models and not specific physicians or actual patients. The ethical and other considerations for this are obvious.

Illustrative material such as dummy prescription blanks, hospital charts, calling cards, memos, etc., are presented as dramatizations.

Composite case histories, drawings and/or photomicrographs are often presented to convey typical clinical indications but unless stated to the contrary are constructed as illustrative cases or situations.

Physical limitations of space in journal advertising make the presentation of all relevant data impractical; therefore, it is suggested that for suitable background on dosage indications and contraindications the standard package insert or more extensive background data be consulted.

The acceptance of material for advertising is based upon several criteria; for example, in respect to safety, all new drugs are required to correspond with the accepted Food and Drug application.

It is suggested that any differences of opinion of individual physicians with any advertisements be called to the attention of the editor, with a duplicate copy of the letter to the pharmaceutical house whose advertisement is the subject of the letter.

THE PUBLISHERS

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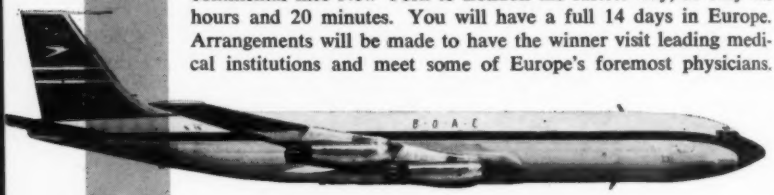

2 SECOND PRIZE: NEW BRITISH TRIUMPH SEDAN

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Resident Physician M

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120 CHANCES TO WIN

Just figure the odds! Only residents and interns eligible . . . the prizes many . . . your chances of winning—excellent.

HOW TO GET STARTED

The contest questions will be of the same type and multiple-choice style as in our monthly Mediquiz *and will be compiled from material appearing in current medical journals* (those published on and after April 1, 1960). So start reading!

Watch for further details in the June issue of RESIDENT PHYSICIAN.

Mediquiz Contest

STARTS IN THE AUGUST ISSUE

From a special conference on internship held at Michael Reese Hospital and Medical Center, your journal brings you this timely article by Dr. Richard H. Saunders.

Resident Physician is indebted to the administration and staff of Michael Reese Hospital for making this article possible.

How Today's Inte

I think I should dispel any illusions immediately by saying I have no data and no slides. I shall try to present some impressions formed during our study to date.

First I would like to tell you a little about the background for this study. As Dr. Luckey indicated, this is being done by the Association of American Medical Colleges, under the direction of a Committee on Internships, Residencies and Graduate Medical Education.

The reasons for this study are probably obvious to anyone who has considered the chaotic situation which exists in regard to internships generally. It has already been emphasized this morning that the role of the internship in hospital programs, both as to service and as to education, has been changing over the years. There is need for clarification of the intern's role in today's educational program.

One can well ask whether there

Interns Look at Internship

Richard H. Saunders, M.D.

is any legitimate place for the traditional type of internship which most of us think of when we use the term.

The objectives of the study can be fairly simply stated.

First of all, we are concerned with the content of the intern year. What does a man do? How does he spend his time? What are his responsibilities?

Second, we are interested in the nature of the teaching program which surrounds his internship.

Third, putting these two together, we are interested in determining how effectively the internship meets the needs of the individual.

Methods

The methods that we have chosen to use are not new. Initially, there was considerable discussion as to how much time should be devoted to the elicitation of data by means of questionnaires, and how much to personal visits to the hospitals.

There were members of the committee who took each extreme, but eventually agreed on a compromise which we are following.

I have visited a number of hospitals, and in the remainder of the study will be accompanied by members of the committee. During a hospital visit, which generally lasts full days, we have interviews with chiefs of the major clinical services, including psychiatry, if the intern spends time in psychiatry. We interview other members of the senior staff who have a responsible role in house staff education; interns on each of the services, residents and senior students. We visit the wards,

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Dr. Saunders, Associate Director of Graduate Education for Medicine, Highland Hospital, Rochester, N. Y., is director of the Internship Study, Association of American Medical Colleges.

attend various conferences, the outpatient department, the emergency ward, the house staff quarters and the library.

Questionnaire

In the second phase of the study a questionnaire will be sent to every intern in all the hospitals included in the study. It will ask the intern to give us a profile of his experience, what he did on each service, how many times he carried out certain procedures, and what teachings he received. We will ask him to evaluate his teaching in terms of whether he found it sufficient for his needs. We feel that we can evaluate such information only on the basis of the personal visit, knowing something of the physical facility and the spirit of the institution.

Administration

A third part of the study will have to do with administrative details, that is, the relationship which exists between the hospital, and the medical school with which it is associated.

I should have made clear in the beginning that this study will be confined to major teaching hospitals of medical schools. It has been the feeling of the committee that we actually have no right to study any other internships. (My own hope is that the A.M.A. Council on Medical Education will see fit to conduct a similar study which will concern itself with non-university hospitals.)

In these visits I have gained certain impressions, and I would like to emphasize that these are only impressions. I would not want to be accused of prejudicing the study, but I think that some of these impressions will be validated by data which will be obtained as the study goes on.

Student, intern attitudes

The first of these is this: In talking with students (and with the current intern class), I find a growing trend to look upon this year as one that is primarily educational in nature. I would like to emphasize that this is not solely because I am talking to interns in university hospitals, but since the same opinion comes from the students who are currently seeking internships.

I think there are several reasons why this trend exists. One of these is that there is a greater awareness by the students of how incomplete is their knowledge of fundamental physiological processes. We have all been fond of saying "No one knows as much as the man who just graduated, and he will never know that much

again." Actually, with the tremendous increase in factual information in all areas of medicine which has been made available, I think all students have less of this cocksure, "know it all" attitude than perhaps was true 20 years ago.

Patient responsibility

In addition to this, there is a keen realization that the greatest opportunities for clinical learning come with patient responsibility under adequate supervision.

Most medical students will say, "This is the year in which I can put into practice some of the theory which I have heard expounded."

"This is the year in which I hope to have real responsibility as a physician in the care of patients".

"This is a time when I can decide what is the matter with this man, or make the decision as to how to pursue the diagnosis."

"It is a year in which I will make decisions to treat or not to treat, and how to treat."

At the same time these men want to feel that there is a senior staff available to them who will keep an eye on them; not to tell them what to do, but to point out areas in which they may be deficient, or areas in which they may be making mistakes.

Supervision

This brings me to the third reason why I feel recent graduates are interested in internship as education: They realize the danger of developing bad habits and repeating errors unless guided by a capable, interested staff who are readily available to them.

Occasionally, of course, there is a man who says, "I have had a lot of spoon-fed education — a lot of theory thrown at me. What I want now is a hospital with many ward patients where I can try these things out with a minimum of supervision." But this group seems to be the distinct minority.

Yardstick

Now, if the graduate looks upon his intern year as one of education, then he has a very real yardstick with which to evaluate the programs that are listed in the internship and residency number of the J.A.M.A. Theoretically, a man should be able to pick from this list at random and be sure of the quality of his internship. In actual fact, we know that this is not true. In looking at the program then, and using education as his yardstick, what sort of questions does he ask about the internship, the hospital and the program?

First, he wants to know: "What is the patient load?" Is there an adequate number of patients for whom he will have major responsibility?

Is there an adequate variety of disease processes represented? Or does this hospital have a selective policy, admitting only patients with rare and exotic diseases? One might miss experience with the commoner things.

Or is the reverse true — that there are too many patients admitted and the intern is so busy in doing new patient work-ups, that he has no chance to sit down and think through the individual patient's problems?

Staff

Other than patient load, he is concerned with the staff of the hospital. Who are these men? What qualifications do they have as teachers? Have they by their past records shown an interest in medical education and teaching? Do they take the time to teach?

For the prospective intern these are among the most important questions that can be asked. A program might look quite good on paper but it may look quite different in the eyes of the intern who is going through the program.

A third point of interest is how the teaching program is organized. More importantly, what are the objectives of the intern programs which are offered? This is a question which we ask the chiefs of departments, all of whom are professional educators. It is a very difficult question to answer.

A fourth question is: how does this program meet the prospective intern's particular needs and desires in terms of his ultimate goal in medicine.

Stimulating atmosphere

Finally, is there an atmosphere in the hospital which is conducive to learning? This is something that is very difficult to quantitate, and difficult to describe. But the atmosphere of a hospital is a very real thing and something that any one of us can sense after spending a short period of time in it.

An atmosphere which is provocative and stimulating makes a man want to learn, makes him want to use the library. It makes him take pride in formulating the correct diagnoses, or proceeding in a logical manner to arrive at a diagnosis. It is a sort of "moral suasion" which makes him want to live up to the best of his capacity.

As one of the speakers at the Congress on Medical Examina-

tion and Licensure in February 1959 phrased it, "We should teach a man to think, to discriminate, to make wise judgments. When this spirit is present, it is alive. When it is alive, it is contagious." Although this may seem vague, I think it expresses very well what all of us feel.

Critical scrutiny

This is the very critical scrutiny we come under when we offer a man an internship. The man who is seeking an educational experience applies these criteria, and then decides that this *is* or *is not* a good place for him.

Having made this decision, then he will ask certain questions about the *kind* of internship; that is, whether he is to take a straight or rotating or a mixed internship.

Now, if we keep in mind the concept of the internship being primarily education, there is little room, as I see it, for argument about the relative merits of the various forms. Here, I am in a little disagreement with Dr. Luckey, which may bring us to some questions later this morning.

Basically, this is a year of increasing clinical responsibilities, a year in which the man learns to develop a true doctor-patient relationship, but one which has associated with it a large measure of teaching. What division of time is made for the various specialties then becomes a matter of individual preference, and need not be a matter of policy decision.

If a man knows that he is going to spend two years after medical school in graduate training, he should decide what it is he needs most in these two years to fit him for his future career.

But by the same token, if a man is going to do family practice in a fairly remote area of the intermountain section of the west, he may of necessity have to be able to take care of various kinds of trauma, to do minor emergency surgery and to set certain fractures. Therefore, he may need this kind of experience during his graduate period.

Division of time

Dr. Oliver Cope expressed it this way at the 1959 Teaching Institute of the Association of American Medical Colleges. "Time is a requisite of medical education, but how it is allotted is not nearly so important as how it is used."

The division of time then becomes important in one respect; that is, if it is done in such a manner as to *interfere* with a man's learning.

I regret to point out that a

satisfactory division of time is not successfully achieved in certain hospital programs.

I hope I am not stepping on anyone's toes, but the classic example of this is the traditional rotating internship, in which a man spends 11 days, 10 hours, and 37 minutes on each of numerous subspecialties of medicine and surgery. During this time he gets to know neither the staff, the patients, nor the problems of either.

It seems likely, therefore, that in giving critical attention to our intern program in the future we should pay more attention to what it is a man needs and how his internship can help meet this need.

90-day specialist

Now, lest someone gets the idea that I have data to support the abandonment of a rotating internship, I would like to make these observations. Actually, I see no conflict between straight, mixed, or rotating programs. The main objective of the year is learning to become a physician and not a specialist. What happens in some rotating internships is that each specialty takes the man for a given period of time and tries to make a 90-day wonder out of him—a 90-day surgeon, a 90-day internist, and so on. This doesn't work.

My favorite example of this is cholecystitis. Now the family doctor sees patients who have cholecystitis; the internist sees them; and eventually the surgeon sees a great many of them. Should we teach that disease process in three different ways? One to the family doctor, one to the internist and one to the surgeon? Well, I suspect we do but it strikes me as a bit ridiculous.

The management of this patient's problem should be from this point of view: "What can I, as a *physician,* do for this patient that will best solve his problem?" Certainly, cholecystitis is the same disease process on the medical and surgical services.

What I am suggesting then is this: if we concentrate on teaching a physician what to do with patients and their problems, he would be taught essentially the same things in medicine and surgery. Therefore, in a rotating experience, he would come up with what he needs to know and his learning would be cumulative from service to service.

We have been asked whether there is a conflict between the intern and the resident. To date I would have to say that the vast majority of interns and residents,

do not feel there is any such conflict, provided these things which we have been talking about are kept in mind.

The intern year is not a separate year as we are prone to think of it, but is only one phase of a continuing medical education which begins the moment a man enters a medical school, and never ends.

Resident staff

The intern program is also greatly influenced by the residency programs. Interns recognize that the resident staff, probably more than any other group of individuals, teaches them the details of patient care. There are many reasons for this but one is that residents are available. They are not so far ahead of the intern that he hesitates to ask questions. He may be reluctant to ask the same question of his visiting physician because he doesn't want to appear ignorant in this man's eyes.

It is, therefore, extremely important in selecting an internship that a man choose one in which the resident staff is a group capable of and interested in teaching.

As to conflict between the student and the intern, this of course depends entirely on how the clinical clerkship is organized and how much responsibility the intern is given.

Senior year

Again, I can only say at this point that there are many programs in our medical school hospitals which successfully avoid this conflict, provide a good educational experience in the senior year, and an equally good one during the intern year.

In regard to the senior year, however, there has been a great deal of criticism, more even than the internship, in my experience to date. This is because many senior students feel that they have an undirected program at times, a program which does not demand of them the best of which they are capable.

I am not implying that they resent free time or elective time. Actually, this may be a valued phase of the senior year. However, if a man is simply told that he has a block of free time and no adequate provision is made for his use of the time, when it is over, he may feel lost and feel that this time was wasted.

There are many ways of utilizing time of the senior year to better advantage than has been done, and still not conflict with the internship. This brings us to the question of whether or not

the senior year of medical school should, in effect, be converted into a rotating internship. I do not have the answer to that. As you know, there are certain medical schools which are currently experimenting with programs of this sort. There are some questions which I would raise in regard to these.

In an era when the great body of factual information is expanding at an enormous rate, is it wise to shorten by one full year the time in which a man receives didactic teaching? Does a man really know enough pathology, physiology, and biochemistry at the end of his third year to become a practicing physician (which is what the intern is)?

One must be careful that putting the senior student into an intern's role does not require of him so much time for routine matters that it takes away from his opportunity to study, read, think, and organize his knowledge. One also wonders whether the majority of students at the end of the third year of medical school are psychologically and emotionally prepared to assume the degree of patient responsibility that the interns feel is so essential to effective learning at this stage of one's career.

Stipends

I would like to close with just one other point, and that is, a brief consideration of the sociological factors which have some bearing on the internship. Up to now I have stressed the fact that students and interns look upon this first year after graduation as a period of education.

Traditionally, we have ignored stipends as being of no importance. This is a dangerous subject to bring up, I realize. But I fear that we have all played the role of an ostrich and hoped that if we buried our heads in the sand this problem would go away. It hasn't. It has become increasingly troublesome. I have tried to get some poll of opinion from medical educators and hospital administrators as to how we should deal with this problem. I have also asked students and interns what they feel would be a fair basis for deciding how much money a man should receive during his internship and residency.

Cost of living

There seems to be considerable agreement that the only logical basis for deciding how much a stipend shall be, is to provide a man with enough money to meet the basic cost of living in the community. This is substantially

more than interns are currently receiving in many hospitals. Where this money shall come from is a knotty problem, but there must be a suitable solution if we seek it.

Staff quarters are important. Twenty-five years ago interns and residents weren't married. They lived in some building either part of or adjacent to the hospital. They did the usual fraternity tricks of short sheets and putting sand in the bed. There was an esprit de corps which seems to be missing from today's house staff.

I think one of the ways that we could revive a bit of that spirit of camaraderie would be to provide housing facilities near the hospital, for all house staff (married or single) so that men with mutual interests would be thrown together while off duty. They would not be so remote from the hospital that they would find it difficult to return to the laboratory or to the library. It would give the wives a better chance to know each other. Such facilities are going to take considerable money.

In a visit to one of the eastern medical schools, a senior student expressed his feelings in somewhat the following way: A man on finishing medical school is 24 or 25 years old. He has had three or four years of college, and four years of medical school. Psychologically he feels the need to establish his family life in a manner comparable to that of his college classmates.

Size of debt

He doesn't expect to be handed all this on a gold platter. It is not the attitude that "the world owes me a living" but a feeling that he would like to go through these additional years, in which he is better qualifying himself to take care of the ills of his fellow man, in such a way that he does not end up with an enormous debt. Just how one solves this dilemma, I'm not sure. We have to consider not only the man's needs but those of society which needs his future service.

I hope that next summer, when we will have all the information that we can obtain, we will be in a position to deal more specifically with some of these points. All I can say is that it has been a most interesting study area. I found everyone to be extremely cooperative.

In Other Words . .

a glossary of phrase

"WN and WD" Anything that had strength enough to crawl here.

"No acute distress." Will probably live until morning.

"Noncontributory." Who has time to do a family history these days?

"Appears to be . . ." Do you know a good dermatologist?

"Grossly normal." From the foot of the bed.

"Within normal values." I forgot what the values are.

"Not reported." Lab closes for coffee at 2.

"Subicteric tint." This disease is supposed to show jaundice.

"Because of the language barrier." Nurse taking temperature

"Cooperative and pleasant." Will probably pay bill.

Harry Unfug, M.D.

...rase...ppearing in case reports

"Uncooperative and hostile." Will probably not pay bill.

"Disoriented and confused." Received phenobarb 30 minutes ago.

"Disoriented as to date." Hasn't read a newspaper since he took sick.

Disoriented as to place." Where did you park your car yesterday, Doctor?

"The rectal sphincter was tender." Aren't they all?

"Grade 1, on a basis of 6." Out of six examiners, one heard (felt) it.

"This is a new patient." We don't know anything about him.

"Does not eliminate . . ." Consult French for differential diagnosis.

"In view of the present situation . . ." Patient took a turn for the worse.

"Thank you for referring this intriguing patient." We don't know either.

Your Patient Sounds Off

Here's a point of view that may help your perspective, a composite picture of "the patient" in your private practice, a two-headed monster and a halo — with fee attached.

Dan Anderson

Sooner than you may realize, you'll finish that residency. Then wham! — you'll meet me. All-important me! Puzzling, puzzled, arrogant, docile, independent, obedient, changeable, constant, fearful, courageous, mixed-up, canny me.

Who am I?

Your private patient!

Necessary me, too. I'm obviously necessary to you. You're definitely necessary to me. How do we get together, and stay together? I'm writing this in hopes of helping us. It's to tell you what I'll expect and demand of you. It's to tell you what you may look forward to from me.

First of all, Doc, remember I'm not provided to you, like the patients you're seeing now as a resident. I can go somewhere else besides your office. Or I can see you once and choose not to come back. Making me want to return is a big, new task you must tackle.

You'll have to humor me, of course, put up with some ways of mine that seem odd and trying. Just for a sample: I wonder if you gritted your teeth a bit when I called you "Doc" at the start of this opus? You're properly proud of the whole title,

TO STOP DIARRHEA

from all points...growing evidence favors

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brand of furazolidone

■ Pleasant-flavored LIQUID, 50 mg. per 15 cc. (with kaolin and pectin) ■ Convenient TABLETS, 100 mg. ■ Dosage—400 mg. daily for adults, 5 mg./Kg. daily for children (in 4 divided doses).

SWIFT RELIEF OF SYMPTOMS

EFFECTIVE CONTROL OF "PROBLEM" PATHOGENS
(no significant resistance develops to this wide-range bactericide)

WELL TOLERATED, VIRTUALLY NONTOXIC

NORMAL BALANCE OF INTESTINAL FLORA PRESERVED
(no monilial or staphylococcal overgrowth)

From a Large Midwestern University:

FUROXONE CONTROLS ANTIBIOTIC-RESISTANT OUTBREAK

An outbreak of bacillary dysentery due to Shigella sonnei was successfully controlled with FUROXONE after a broad-spectrum antibiotic had proved inadequate. Cure rates (verified by stool culture) were 87% with FUROXONE, 36% with chloramphenicol. Only FUROXONE "failures" were those lost to follow-up. Chloramphenicol failures subsequently treated with FUROXONE responded without exception. FUROXONE was also used effectively as prophylaxis and to eliminate the carrier state. It was "extremely well tolerated in all 191 individuals who received it either prophylactically or therapeutically." Galeota, W. R., and Moranville., B. A.: Student Medicine (in press)

EATON LABORATORIES, NORWICH, NEW YORK

"Doctor," and having it chopped short may grate. But face it, I'm still going to call you "Doc" sometimes, so learn to take it.

This doesn't mean I'm trying to whittle away your dignity. I expect you to be dignified, but with inner, essential dignity, not the kind that sets big store by titles and trappings. Dignified, yes! Pompous, no! Chest out, but not encased in a stuffed shirt. Head high, but not nose in air. Just you be a skilled physician; be a strong support to the weakness that brings me to you, and my thoughts will clothe you with all the real dignity you could desire—even though I may stick to my habit of calling you "Doc."

Of course, I might occasionally be a cringing neurotic who wants medical commands as from on high. I'll put you on a throne. Or, I may resent your superior knowledge and tear you down. I'm the most varied critter you ever met. A fretful mother, a stoic elder, a shy adolescent girl, an adolescent boy, even shyer; a desperately ailing man who doesn't want to acknowledge the fact, an unfulfilled woman who craves a physiological explanation for her trouble of spirit (with your help needed just the same) —or a thousand and one persons more. You'll have to figure me out each time, and handle me accordingly.

Business principles

I'm very big about it and grant you a right to a living, even a good one; though I may force you to work like a whole beaver tribe to earn it.

I'll pay — more often, more gladly than some dismal tales of

The first specific aldosterone-blocking agent...

ALDACTONE™

effectively extends the medical control of edema or ascites.

It introduces a new therapeutic principle in the treatment of...

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THE NEPHROTIC SYNDROME • IDIOPATHIC EDEMA

ALDACTONE introduces a new class of therapeutic agent, the aldosterone-blocking agent providing:

satisfactory relief of resistant or advanced edema even when all other agents, alone or in combination, are ineffective or are only partially effective.

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ALDACTONE acts by blocking the effect of aldosterone, the principal mineralocorticoid governing the reabsorption of sodium and water in the distal segment of the renal tubules.

By so doing Aldactone establishes a fundamentally new and effective approach to the control of edema or ascites, including edema resistant or unresponsive to conventional diuretic agents.

Further, because of its different site and mode of action in the renal tubules, Aldactone has a true, highly valuable synergistic activity when used with a mercurial or thiazide diuretic.

What Physicians May Expect of Aldactone

It is fully expected that Aldactone will change present medical concepts of the therapeutic limitations of managing edema. Many patients living in a greater or lesser state of edematous invalidism can now be edema-free. To others, gravely ill, Aldactone will be life-saving.

When used alone, Aldactone will produce a satisfactory diuresis in about half of those patients whose edema is resistant to conventional diuretic agents.

When Aldactone is used in a comprehensive therapeutic regimen, which includes a mercurial or a thiazide diuretic, a satisfactory diuresis and relief of edema may be expected in approximately 85 per cent of edematous patients *who would not otherwise respond.*

DOSAGE: For most adult patients the optimal dosage of Aldactone, brand of spironolactone, is 100 mg. four times daily. Aldactone should be administered for at least four or five days before appraising the initial response, since the onset of therapeutic effect is gradual when it is used alone. Aldactone manifests accelerated activity with greater response as early as the first and second days when used in combination with a mercurial or thiazide diuretic.

SUPPLIED: Aldactone is supplied as compression-coated yellow tablets of 100 mg.

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Research in the Service of Medicine

disregarded doctor bills suggest. If I grumble once in a while, I do the same about the milk bill, too. But, a businesslike transaction is respected. So be businesslike.

Money will have become an essential part of our entire proceedings, to be mentioned and taken into account along with the rest. It's far from the cream of our relationship, but it's there—homogenized in, you might say. I'm making this point strongly because this may be a new aspect of medicine to you.

Estimate

Do your best to let me know what I'm finally going to have to pay. If I run a store, I price my goods plainly; you can come close to that by giving an estimate, revising it from time to time. Try to avoid the unpleasant moment when I come to you and say, "Gosh, Doc, I had no idea your bill would be that much!"

You're going to be in business on a broader scale than just taking in cash. A shopkeeper calls me his customer. And you'll call me your patient. Both of you want me to come to you to get something of value. You can offer an immense value. If I don't come and get it, I'm the one who's worse off; but all your training and knowledge will go to waste. So don't be ashamed or sorry or hesitant about being in business.

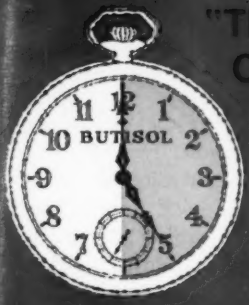
Your income is earned and deserved by providing me with the science of medicine and the art of making it easy and pleasant for me to take.

Recommendation

You can't, it's true, use the devices a shop does to attract my attention. Your code of ethics forbids anything that smacks of advertising. (I respect the code, but its strictness sometimes puzzles me.) So your best method is to treat me right — "treat" in a larger than merely

ABOUT THE AUTHOR

Dan Anderson reports he was eager to handle this assignment. "I'm just grabbing a chance to do the prescribing for a change . . ." He began a newspaper career on the Moline (Ill.) Dispatch, put in 22 years on the New York Sun covering science and medical news, and had a three-year stint as editorial writer on the San Diego Evening Tribune before holing up in Chapel Hill, N. C., to live the life of a free-lance writer.



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medical sense. I'll stick with you.

And I may make a special point of telling my friends how good I think you are. Then you'll have the unbuyable, best advertising any firm or person can enjoy—word-of-mouth recommendation.

But back we come to the doctor-patient relationship, which really is more than that, a person-person relationship.

And here's the important bit: Every time I come to you or call you, I'm afraid I'm going to die.

The fear may lurk so far in the back of my mind that I don't actually recognize it. I may, out of either courage or cowardice, suppress the recognition. It's still there, however far in the mental shadows.

Hyper

Perhaps I have no more than an extra-sore hangnail. Yet, I can without strain conjure up a train of visions of spreading infection, gangrene, vain amputations, pall-bearers!

You won't encourage this fear; only a quack would do that. A lot of your task is to calm it. But you should take it into account. It can explain much odd behavior of mine; for example, why I'm so often hyper in your presence—hyper - chatty or hyper - stolid or almost any brand of hyper.

There's nothing more important to me than my health and my life, and they're my reason for seeing you. This fills our contacts with intensity. If you seem to give a quick brushoff to the engrossing subject of my health, I rate you as cold as a polar iceberg, and no more pleasant to visit.

Reassure

Remember, I'm hypersensitive in this situation. Give me even a hint that you look on me as some sort of symptom-bearing bush, cast a glance that suggests you're looking at me like a page in a medical text, glaze your expression as though I were telling a dull, old tale, and I'll be rebuffed and sore where no salve will help. I'm not asking that, if I display a wart, you turn verbal somersaults and exclaim that you never in all your days saw anyone with such a wart. You may do well to assure me by saying you've seen that type of wart before, and the folks with it did fine.

But don't belittle my wart too much. Rather—and here's a distinction that may seem fine but is vastly important—don't belittle me, with my wart, at all. Here and now I have a wart and I am presently, personally bothered by it. Respect my feelings about that

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Generally a single evacuation of soft, formed stool without catharsis or straining results.

"A gentle but effective laxative"* In tablet form Dulcolax is eminently convenient when overnight action is required. For more prompt effect Dulcolax suppositories usually act within the hour.

*Archambault, R.: Canad. M. A. J. *81*:28, 1959.

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Geigy

circumventing the enema

wart. It may be trivial, but what I think about it isn't. It's the reason for our encounter, and that alone gives it importance.

And say, Doc, never let yourself speak or so much as think of me as "the wart." If ever I hear you describe me or any patient as "the appendectomy," "the Pott's fracture," "the Gleepus-Schmeepus syndrome" or by the name of any medical condition, I'll take it miles amiss. I'm at least "the patient with the wart" who has asked you for help with it.

Think of me in such completeness and put your feeling across to me, and when I say "Doc" it will be a heart-warming word.

Devious approach

Also, pay attention to more than the wart and you make surprising discoveries. I'm frequently devious in my approach. Give me a chance, and I may go on to reveal a deep trouble, far different from the wart, far more serious, far more worth your attention from both our standpoints.

Bear in mind that when I tell you my presenting complaint, I'm sometimes doing little more than sort of saying, "Hello."

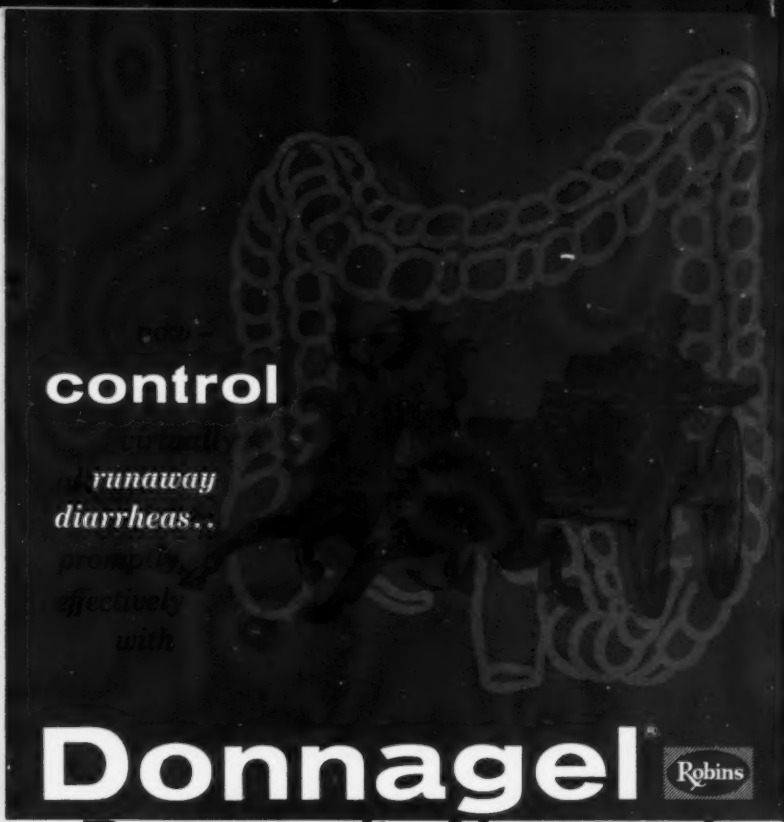
Give me plenty of time or, anyway, act as though you were doing so. There are ways to put the impression across. Take ten minutes with me, and drop in a casual, extraneous remark, like saying you saw the zinnias in my yard the other day and they look fine. I'll feel that it's been longer than ten minutes. This rule will have to be broken if I'm a forever-talker. But even if I am, seek some gracious way to cut my gabbing short.

Punctual

You still shouldn't take up my time unnecessarily. I won't relish sitting for hours, or even for too many minutes, in your waiting room, especially when it simply allows me time to think up new reasons for dread.

Try, too, to keep a *dependable* house-call schedule. Arrive close to when you say you will, and don't set times you're unlikely to meet. Give yourself leeway for the unexpected, but remember that on the dot is best, early is fine, late distressing. My condition is central to me. I understand I must share your attention, but I appreciate it immensely when a period is set and kept for focussing your attention solely, undividedly on me.

Now, what do you know about health? This isn't a catch question, though it has caught a lot



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DONNAGEL: In each 30 cc. (1 fl. oz.):

Kaolin (90 gr.)	6.0 Gm.
Pectin (2 gr.)	142.8 mg.
Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Phenobarbital (¼ gr.)	16.2 mg.

DONNAGEL WITH NEOMYCIN

Same formula, plus

Neomycin sulfate	300 mg.

(Equal to neomycin base, 210 mg.)

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of beginning practitioners. You've been dealing with illness, learning about illness, just about living with illness. Can you have lost sight of health? It's the goal you and I seek together. Could you fail to see the health forest, from so much looking at the twisted trees of illness?

It's a real risk in your profession, especially in the concentrated training time. Yet your aim and my wish are the same—perpetuation and restoration of my health. You'd be wise, then, to carry a clear picture of it in mind: a decently normal, satisfactory state of health.

A little learning . . .

Now I want to take up my ignorance, doctor; never underestimate it in your special field. (You needn't take me for an all-around fool, either, unless I prove it abundantly.) Realize that I'm not learned in medicine and its terms, but assume I have common sense. In fact, you'd better be exceedingly wary whenever I display some smattering of physicianly lore.

It may mean I've just finished reading the latest popular medical article in a newspaper or magazine, gleaning dabs of data with no guarantee of full understanding.

I advise you always to take my bandying of technical terms of medicine as a danger signal. If you let yourself be fooled into considering me anything like fully informed, you'll pass over great gaps in my knowledge. The way popularizers of science pour out writing nowadays, almost any literate person is likely to have read that Myomycin may help some obscure Balinese fever—and still think that five grains of aspirin would mean five of the standard tablets. Always consider my little learning a dangerous thing.

Analogies

Talking to me about my health, go step by step, use commonplace illustrations and analogies as much as you can, remember I'm likely to be in a bit of a tizzy, quick to misinterpret for good or for ill. Ask occasional questions to make sure that I'm really getting into my head what you want to put there.

Anxiety speaks

I hope you've noticed, doctor, that I've refrained from telling you how to practice medicine—what pills or shots to give, that is, whether to use silk or catgut sutures, and all such. I said I took your skill and learning for granted. Almost all the time I

do. It's particularly easy now, when I feel well and calm. But sometimes I get a pain—go in to see you—and start to prescribe what you're to prescribe. Please excuse me. I don't mean to reflect on your ability and judgment, but I'm upset and very anxious.

Perhaps I've just read another article about the marvels of Myomycin, or a pal had a sharp pain in his somewhere, and his doctor gave him a slug of Myomycin, and he didn't die, after all. So I romp into your office and tell you that you ought to give me Myomycin.

You know best

Deal with me gently, Doc, but firmly. Stick to what you think is best because, after all, you do know best. Point out that my complaint isn't a rare Balinese fever. Remind me that the same twinge went away once before without fancy, costly shots. Perhaps you could tell me that it should yield again to the previously successful treatment.

In about a month, I may be proclaiming, "Doc could have given me that newfangled Myomycin that's so doggone expensive, but he knew an easier, better way to cure me. He's one fine doctor, he is!"

Impression

For, though you're in practice by yourself, you're a representative of all doctors. I'm too much given to categorizing, and much too much to lumping all physicians into a class that behaves like the few I've met, or the last one I've encountered. Doctors, they're no good!" I'll explain, or, "Doctors, they're grand people!" It will really mean that I just saw a doctor I didn't like, or one I did. You may be that one, doctor, so for the sake of the AMA plus, strive to impress me well.

So far, I've discussed your behavior, while you were practicing your profession. Doc, whether you like it or not, there's more to come. Brace yourself.

Appearances

You'll find I've put you on a pedestal. Not way up there, but up. Exalted position has its gratifications, but a high perch frequently proves less than entirely comfortable. Not only do I watch you in your office, but outside, too. That can be a bother.

I expect you to keep up appearances, but not gaudily. When, for instance, you buy your next automobile, you'd better think of suiting me as well as pleasing yourself. I think you deserve a good car, surely one that

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new oral prothrombin depressant

control at every stage of anticoagulant therapy **rapidity** of induction and recovery time **predictability** of initial and maintenance dosages **stability** of therapeutic prothrombin levels during maintenance therapy **reversibility** of anticoagulant effect with vitamin K_1 preparations... rapid return to therapeutic levels on remedication

Well tolerated and relatively nontoxic—no nausea and vomiting, proteinuria, agranulocytosis or leukopenia yet observed—chromaturia infrequent and transient.

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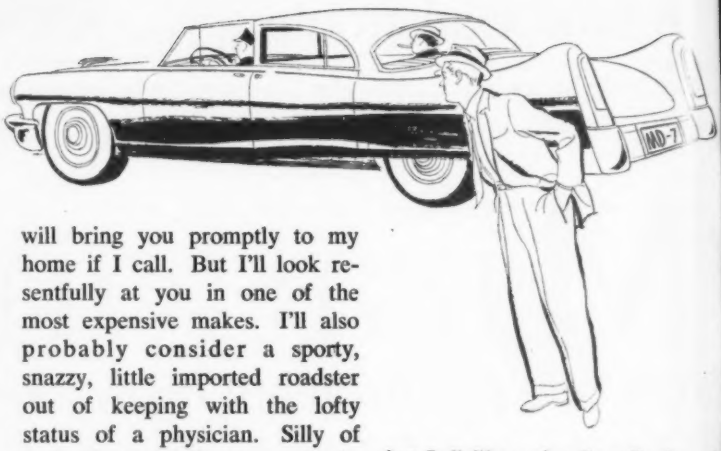
For complete information on indications, dosage, precautions, and contraindications consult the Schering Statement of Directions.



will bring you promptly to my home if I call. But I'll look resentfully at you in one of the most expensive makes. I'll also probably consider a sporty, snazzy, little imported roadster out of keeping with the lofty status of a physician. Silly of me? Granted. But true, all the same.

Conservative

The rule holds concerning your house, your clothes, your possessions of all sorts, and those of your family. Let them be on the conservative side. If some day you begin to subscribe to it, let the Wall Street Journal stay out of my sight. I'd rather think of you poring over the Annals of Whateverology than studying the stock tables.

If you do anything that flaunts signs of superhigh prosperity, I begin to begrudge it. A feeling hits me that I had to have a pain so you could own a bond, and this grates on me. I'm not against your having valuable belongings, but I dislike a dazzling display of them.

Never, doctor, let me see you even a trifle tipsy. I want to think of you as ever ready to handle a call. Avoid letting me see you dirty or disheveled, unless there's a good reason such as working in the garden or playing tennis. You don't have to look scrubbed for surgery all the time, but I'd sort of like you to come fairly close to it.

Silly? Sure it is. But it's a common form of silliness and is not to be laughed off.

Take a middle course, doctor, in public and social contacts. *And give your opinions about topics outside medicine modestly.*

I may attach too much weight to what you say, because you're

anorectal comfort in minutes For full symptomatic control in hemorrhoids, proctitis and pruritus ani *start* treatment with 2 Anusol-HC suppositories daily for 3 to 6 days to eliminate all inflammatory symptoms rapidly and safely. Then *maintain* lasting comfort with 1 regular Anusol suppository morning and evening and after each bowel movement. Neither product contains analgesics or narcotics, will not mask serious rectal pathology.

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WARNER CHILCOTT

AN HS - 01

a doctor. You are on that pedestal. Or worse, I may be expert on some subject about which you sound off, and catch you in a serious error. Then, unreasonably but almost inevitably, I'll say to myself, "Why, he doesn't know a three-em-dash from an ampersand, so he may not know a wart from a kidney basin."

My scrutiny of all your life may be irksome, and my equating you with a single subject, health, may be a bore. School teachers and clergymen have to put up with the same sort of thing (though it's odd that lawyers don't get so much of this kind of treatment). At least, you have company in the situation, and it's proof that I hold you in special esteem. It's a compliment, even though sometimes I cause the head that wears an M.D. crown to lie uneasy.

Riches, surprises

You're coming out of the cloisters, doctor, into my world that will welcome you, stand ready to laud and reward you, but at times will shove you around. You're in for surprises, good and bad. You may find among your fellow physicians, with whom you'll have to balance relations delicately, an occasional example of a complete heel. To make up for that, the chap who installs your telephone may be a grand guy. Study them both for tips on what not to be and what to be, what not to do and what to do.

In your future are vexations and unpredictable problems, but also the prospect of a rich life in far more than the financial sense. Waiting for you are true dignity and respect, gratitude and glimpses of faces you'll know you have made rosier and turned smiling.

You've been hard at it, learning your medicine. I hope this piece has hinted at what you must discover about me—your private patient. You need me, doctor, and I need you greatly. I hope we can have a long, mutually enjoyable future together.

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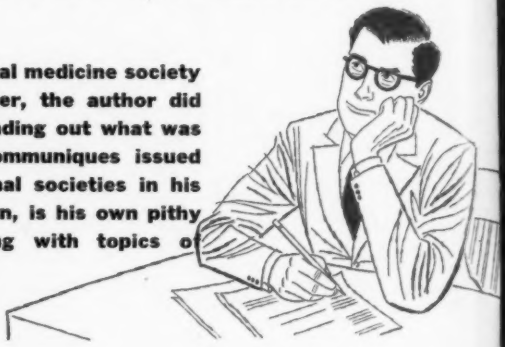
SIN MS-01

WHAT IS AN INTERNIST?

Chosen by his internal medicine society to write a newsletter, the author did his homework by finding out what was current in other communiques issued by state and national societies in his specialty. Here, then, is his own pithy "newsletter" dealing with topics of moment in his field.



Robert J. Needles, M.D.

I recently found my desk piled high with dozens upon dozens of mimeographed sheets. These consisted of newsletters from state and national internist organizations, as well as copies of letters from various individuals and copies of replies. It was quite simple. Having complained overmuch of scanty communications, I found myself designated to correct the deficiency by providing a newsletter for our local internal medicine society. (He who is impatient with the menu becomes mess officer.)

It required most of an afternoon to read the material. About half way through the task I realized that my work resembled that of a music lover who has but one record. No matter how poignant the refrain or skilled the performer, significance of the thematic content diminished with repetition. I was left with what might seem to be a rather absurd impression.

You see, from this mass of newsletters and correspondence there emerged two major issues which seemed to comprise the bulk of editorial ferment. These are the same two issues which have plagued us, in Florida, since

stomach under fire Even under stress and tension Gelusil antacid adsorbent keeps peptic ulcer patients pain-free all day long. Gelusil physically coats the ulcer with a protective, long-lasting, acid-adsorbing gel while simultaneously removing excess acid. Pleasant tasting Gelusil is *all* antacid—nonconstipating—contains no laxative.

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WARNER CHILCOTT
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GE HS- 01

our beginnings. They existed before our society of internal medicine was formed, and they have occupied much of our discussion time. They continue to plague us, and now, as I saw, the refrain has become national, and returns again and again—and again . . .

Definition

In working over these two well beaten dilemmas, it is not my hope to dispel their murkiness. On the other hand, what else is there to discuss? Note how familiar the refrain:

1. What Is an Internist?
2. What Are the Services of an Internist Worth?

The answer to the second, of course, depends upon the answer to the first.

What is an internist? The very idea of expecting a simple definition is an invitation to failure. The answer depends, first, upon whose description is accepted. And, since none of those descriptions are without prejudice, we can only conclude that we are somewhat of a mystery to those about us.

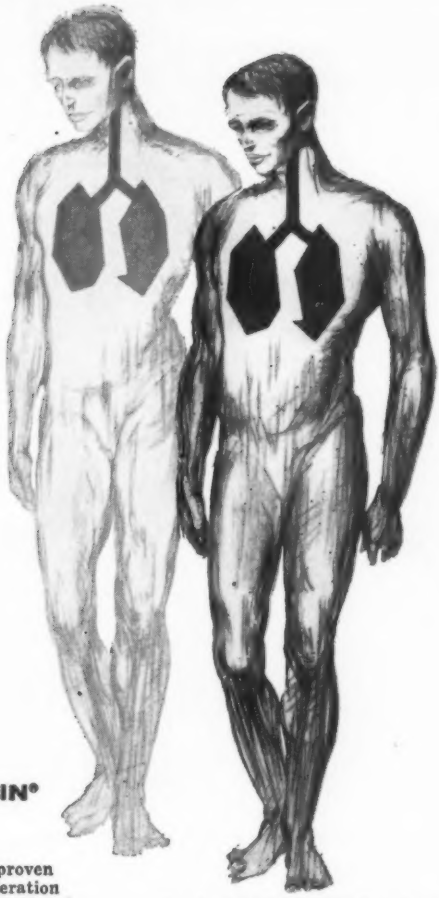
Surgeons are not sure, although many of them seem to believe that we are rather peculiar fellows. They understand that we do no surgery, that we are reluctant to scrub and observe their admirable skills, and they have finally come to understand that we own little affection for the administration of anesthetics.

General practitioners are not quite so indefinite, asserting that we are at once over-shy, overtrained, and over-confident of our skills.

Of course, to ourselves we are delightful fellows, not improbably because we see things rather from the same level. That level is presently not entirely pleasing to us, nor is it one where we may be expected to remain either complacent or agreeable.

Richard Weaver has remarked that, in seeking definitions, it is of first importance that we adhere to genera and avoid concentrating upon individual types or specimens. In other words, one could with some decency compose the definition of a human being. But how could one define George Washington, or, to pick a contrast, Harry Truman?

Internists, then, may be defined. One internist is indefinable; we participate in the variety which is the essence of human individuality. To believe that each member of an entire specialty group can be compressed into some neat and succinct definition is to ignore those very differences we ourselves cherish. Internists,



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***Supply:* Cosa-Terramycin Capsules—250 mg. and 125 mg. New Cosa-Terrabon* Oral Suspension — 125 mg./5 cc. (tsp.), preconstituted, fruit-flavored, bottles of 2 oz. and 1 pint. New Cosa-Terrabon Pediatric Drops —100 mg./cc. (5 mg./drop), preconstituted, fruit flavored, 10 cc. bottle with calibrated plastic dropper. Terramycin Intramuscular Solution† —ampules of 100 mg./2 cc. and 250 mg./2 cc.**

Terramycin is also available in a variety of topical and local forms to meet specific therapeutic requirements.

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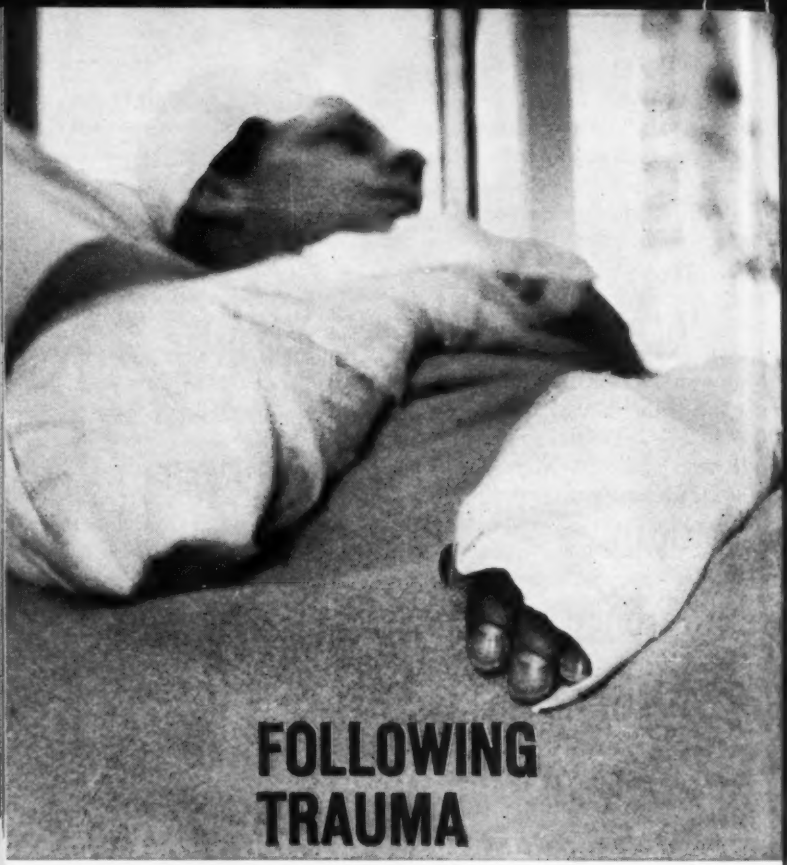


nutritional therapy in the "therapeutic" jar

STRESSCAPS helps meet increased metabolic requirements in burns, fractures and wounds. Abnormal levels of water-soluble vitamins are suddenly required with other nutritional factors—just as the stress reaction induces severe depletion[1, 2] and alters metabolism.[3] High potency supplements must be administered[1, 2] as provided by STRESSCAPS, to support rapid recovery and prevent general complications of metabolic failure. Of "therapeutic" importance to the out-patient, the attractive STRESSCAPS jar is a convenient reminder of daily dosage . . . insuring adequate intake over the therapeutic course.

Each capsule contains: Thiamine Mononitrate (B_1) 10 mg., Riboflavin (B_2) 10 mg., Niacinamide 100 mg., Ascorbic Acid (C) 300 mg., Pyridoxine HCl (B_6) 2 mg., Vitamin B_{12} 4 mcgm., Folic Acid 1.5 mg., Calcium Pantothenate 20 mg., Vitamin K (Menadione) 2 mg. Average dose: 1-2 capsules daily.

1. Richardson, M. E.: J. Am. Osteop. A. 57:562 (May) 1958. 2. Mason, M. L.: Northwest Med. 57:1439 (Nov.) 1958. 3. Coleman, S. S.: Am. J. Surg. 97:43 (Jan.) 1959.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

STRESSCAPS®

Stress Formula Vitamins Lederle

perhaps more than any other specialty group, deny the possibility of categorization of men in lumps, like lard or pudding.

Group

If these things be true, our first requirement is that we stick to genera, and agree to no breaking down, for local, personal or other reasons, the defined and defensible concept of internal medicine.

An internist can only be, by definition, one of that group of specialists who practice internal medicine and who is, by achievement of that status, an internist. Not good enough, of course, and so on we go, as if searching in a darkened room for a black cat gone elsewhere.

Definition

The price of honesty, Lincoln is supposed to have said, is to stick to argument from definition, and allow no multiple subclassifications. To reach agreement, or to defend ourselves in any argument from definition, we are warned to stay out of the excluded middle. In other words: have a clear definition of ourselves as a group, stick to it, and allow no fractionating.

Above all, we must never wander near the middle of the road, for there lies a more savage destruction. Near the middle of the road there will be many types of doctors, but few genuine internists. Others we have, in numbers starting when subjected to analysis.

Listings

In fact, I examined the yellow section of our telephone directory. Here, as you may know, each doctor is allowed to nominate himself for greater glory in the profession. He chooses what he shall be called, and unless it do shattering violence to all truth and history, he is allowed to persist in his little vanity. So I found (these are my own figures, and I do not defend them as absolute) that in St. Petersburg we have the following:

- 27 General practitioners (some of whom admit also to another skill, such as obstetrics)
- 41 General practitioners, who fail my definition of internist and also fail the definition of an internist established by the Florida Society of Internal Medicine. In the directory, however, they are described, by themselves, as "internist," or "limited" to internal medicine, or to "general medicine," or some such.
- 30 Internists, veritable internists, by my own or any other definition.

• 6 Internists, who are internists by my own affection or definition. They have not, however, as yet secured official documentation of their skills.

So, where are we? We are, first of all, outnumbered.

Nonetheless, if we are come this far only to count heads, we might as well enliven our labor by breaking a few heads. Quality must interest us more than mere numbers.

Weighed

In our profession votes are not only counted, they are weighed. We have 30, perhaps 36 individuals in a proper classification of internists. Another 41 doctors are pleased to identify themselves with us, although we have not invited them. Some 27 call themselves general practitioners, and that they are.

Of course, you may say, this is St. Petersburg, and St. Petersburg is unique. Perhaps, but if you will study your own telephone directories, it is possible you will find a similar pattern in your own town. And, if this is true, picture yourselves sitting down, some fine month or year, to classify and estimate the professional qualifications of the doctors in your own community. Each of you would be able to come up with some sort of stratification. Each of you would accept some cross-matching. There would remain an excluded middle, some with one sponsor, some with no advocate save himself.

Of course, one general practitioner may prove to be quite a formidable protagonist in behalf of his own prerogatives. Nothing short of your demand for proof of what he so proudly claims will slow him down. This will be humiliating to you and insulting to him, and you may very possibly have thereby made an enemy for life. Is it not likely, therefore, that instead of this proper choice, you will fall to trading votes, and conceding? Is it not possible that you will end with a non-homogeneous mixture, evil and unblended? Is it not possible also that you will be well on your way to assisting in the destruction of your state society and also the parent body?

Mister and barber

Internal medicine has been well recognized, though with agreeable modesty not insistently so, for many generations. All doctors were, at one time, physicians. When surgeons were still barbers, and even more recently when they were yet called "mister," we were physicians. We have surrendered

many of our prerogatives, and have allowed others to assume authority in narrow specialities once a part of our domain.

The parts, it appears, have reunited outside our central body. They proceed to the direction of parent, children, and ordering of their accumulated privileges. Osler was an internist, was he not? And Henry Christian? And Francis Peabody? And James B. Herrick? All those splendid gentlemen who taught us Theory and Practice—these were internists, were they not?

Already selected

The American College of Physicians began to decide, in the twenties, which doctors could rightfully be called "internists." The American Board of Internal Medicine began a sharper classification in the early thirties. Why deliberate we so solemnly, once and superfluously again, on how better to select those already selected by others?

It is quite simple, this business of deciding who is an internist. It has already been done for us. It has been done by those who trained toward "those Board Examinations" and "that College," and made it. These decisions have been made, with the cooperation of those who so desire it, by a succession of honorable physicians, on Committees of the College, in Boards of Internal Medicine. These qualifying authorities are yet in existence, are yet available, and are still better than any substitute we could possibly hope to establish, on a local or state level.

Difficulties

It is on this local level where pressures from friends, families and the community at large will work to vitiate impartial choice. Others will be impatient, and that impatience will not be allowed to settle by the eager applicant. Others will understand but poorly a rejection which seems to have been made for no reason (apparent to them) except the personal bias and prejudice of those doctors also resident in that community. A national standard, whether of the Board or College, is not a barrier to admission to our society.

It is, instead, defense against those about us who will use reasons, arguments or even threats unless there be a larger requirement. Reliance on demonstrated, provable qualifications will spare us timid acquiesence and also protect us from retaliation, for we also are ruled by law, not men. So let us have done with this part of

the difficulty, in any event.

An internist eligible to join our state organization has been defined as one who has exposed himself to a proper course of training.

He is not only eligible for the Board or the College, he has taken and passed his examinations. He holds unimpeachable Certification or College Fellowship. Of course, not all those who are so accredited are excepted, for on local levels character is of importance. There are exceptions, however, you will say. Of course there are. There are exceptions, largely self-determined, as your exception in another direction was self-determined.

Requirements

These are a scattered few, and regardless of how virtuous they may be, they remain nonportfoliod, and their failure to achieve definable and defensible status as internists must not be allowed to dilute the quality which we have determined to be proper.

Our concept, never seriously questioned, includes stated training, authentic and completed certification, and recommendation from those who can recommend the individual's personal qualities. By holding to this standard we need admit to no false conceit. Nor should we be ashamed of what we have, at no small labor, achieved.

It is not our desire to hold others back. If others conceive of themselves as victims of a narrow prejudice, there is a good method of correcting this situation. It is that route that we took, and to which they are recommended, and which is still open to them. Meanwhile, let us be about our business, which is that of internal medicine. It is not helpful to spend our time placating a few unhappy spirits, who are, after all, physicians, doctors of medicine, and not degraded by any unless by themselves.

Summary

Now you may say, "This is no newsletter!" True. Does anyone have anything new to talk about?

MEN WHO MADE THE MEDICINE

The Klines, father and son, sparked the growth of their company with energy and imagination. By introducing quality control, paving the way for pure food and drug legislation and fostering research, they left their imprint on the entire pharmaceutical industry.

THE KLINES OF SKF:

Mahlon N. Kline joined as bookkeeper, became key man in firm's growth.

On February 15, 1865, Mahlon N. Kline, a neatly scrubbed 19-year-old, joined the Philadelphia wholesale drug house of Smith & Shoemaker. That bleak, rainy day eventually became a historic one for the small firm at 243 North Third Street as the new bookkeeper proved to be a unique employee.

The only son of a Berks County (Pennsylvania) farmer, Kline attended Philadelphia public schools and in 1865 graduated from Eastman Commercial College in Poughkeepsie, New York. When he joined Smith & Shoemaker that same year, the

Company leaders (l to r): Harry B. French; George Smith, who founded his Philadelphia drugstore in 1841, and Mahlon K. Smith, nephew of founder.

A Legacy of Leadership

company president was George K. Smith.

It was Smith who, in 1841 during the early days of patent medicines, founded a one-man drugstore in the center of Philadelphia's business district. With quinine and crude drugs the only pharmaceuticals available to the medical profession, Smith built a good business by providing physicians throughout the country with reliable and prompt service. However, in 1861 he suffered a sizable financial setback when the large turpentine commitments in the South were canceled upon the outbreak of the Civil War. With the financial support of such friends as George Y. Shoemaker, who bought into the firm in 1863, Smith survived the economic crisis, and by 1865 the company was in need of an energetic bookkeeper. Young Kline appeared quite capable of filling the position.

Kline was too keen and ambitious to restrict himself to bookkeeping. He applied himself to other activities of the firm and, within a few years, his efforts resulted in the addition of a number of new and large accounts. His energy and talents recognized, Kline was made a partner

in the firm in 1868. After the death of George Y. Shoemaker and George K. Smith, Kline and Smith's nephew changed the firm's name to Smith Kline and Company.

Great development

Under the dynamic Kline the business, with sales of little over $100,000 in 1868, underwent phenomenal development. In 1878 the company moved to larger quarters, and by 1883 it had modified its wholesale-retail business by establishing a rudimentary pharmaceutical laboratory for the manufacture of several basic products. Three years later, when sales had climbed to over $770,000, Kline added a small research laboratory to the company.

In the early 1890's another Philadelphia drug firm, French, Richards and Company, was absorbed and its president, Harry B. French, became vice president of Smith Kline & French Company. Hundreds of separate and varied products, including liniments, tonics, hair oil, cough medicine and numerous home remedies, comprised the product line of the expanded firm.

By the turn of the century perhaps the most notable innovation of the house was the filling of orders upon the same day they were received. Orders received by mail or telegraph in the morning were sent out in the afternoon. In this departure from the old and leisurely methods of order filling, Smith Kline & French became the pioneer among the wholesale drug houses of the country.

Under Kline's direction the company also instituted the procedure of having all drugs bought by the house passed upon for quality by laboratory chemists before they were put into stock, a practice which soon became universal after the enactment of the Federal Food and Drugs Act of 1906.

Praise

After the enactment of the Act, the chief government chemist praised Kline for his efforts in promoting such high inspection standards and said the country owed a great debt to Mr. Kline who "first helped in getting such a far-reaching and salutary act on the statutes, and second, in giving such valuable assistance in the preparatory work necessary to its enforcement."

By 1902 sales had climbed over the $3 million mark and the company was likewise growing in number of employees, one of

which was Kline's 22 - year - old son, C. Mahlon Kline. The younger Kline, who started as an analytical laboratory worker, testifies to his father's bouyant energy during those years. "He was a hard man to keep up with—always on the go, looking for new things to do and better ways of doing everything."

While building a sound and reputable business, the elder Kline found time to distinguish himself in many other organizations and associations. He joined the National Wholesale Druggist Association in 1882, and in 1885 was made its president. For years Kline served as chairman of the Association's proprietary committee and later as chairman of the important legislative committee.

Many activities

Among his many other activities, he served as chairman of the board of the Philadelphia College of Pharmacy and as president of the Philadelphia Drug Exchange. He also helped found the Philadelphia Chamber of Commerce and served on numerous national affairs committees.

By 1909 he had crowded many memorable moments into his 63 years. A deeply religious man, he served as superintendent of a Sunday school, and president of the brotherhood of St. Andrew. On November 27, 1909, Mahlon N. Kline rushed to attend services in his neighborhood church. He died removing his coat.

Summing up

An article that appeared in a Philadelphia newspaper cited his remarkable career. It read: "It will be wondered by those who did not know the man how he could accomplish so much without a physical and mental breakdown, and the answer to the query is that he was happily possessed of a perennial flow of good nature, which made the usual irritations of an extremely busy life leave but little effect upon his stalwart frame.

"Again, he was charitable of mind, as he was with his pocketbook, and he wasted no time in worrying over things that couldn't be mended, or in . . . malice or hard feelings against any man. That he was carrying too great a burden of mental labor is undoubtedly true."

Behind him Kline left a remarkable record. The company he had developed was sound, and the son he cherished possessed the attributes of leadership.

Upon his father's death C.

Triple Sulfa Cream

TRADEMARK

- in mixed vaginal infections
- against secondary invaders in trichomoniasis
- in postpartum care
- after vaginal surgery

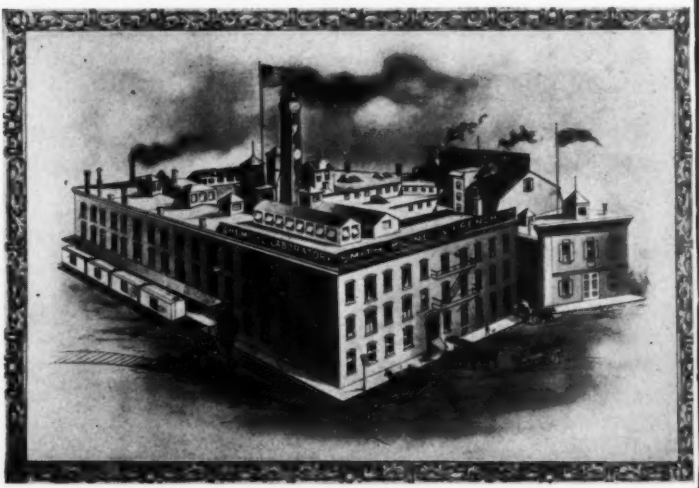
Ortho

Mahlon became the vice president of the company under Harry French. Through their efforts sales grew to over $7 million by 1920. In 1921, when C. Mahlon Kline became president, the company was distributing about 15,000 products, many of which were over-the-counter remedies. In the next few years, Kline laid the groundwork and established the long-range plans which were to bring about his company's growth into one of the world's leading pharmaceutical firms.

Among the first to recognize that research held the key to the future of his industry in the service of medicine, he was confronted by a situation both discouraging and promising. At that time the academic scientific world and commercial firms were still separated by a gaping chasm. Kline realized that the academic institutions had the highly skilled personnel necessary to carry on drug research but often lacked the financial means to pursue the search for new therapeutic agents.

His foresight led to a conviction that by supporting the work of scientists in various research centers he would be adding to medical knowledge and progress and, at the same time, intensify-

In 1898 the pharmaceutical firm bought a manufacturing plant on Delaware Avenue.



ing the research efforts of his own firm. This policy, begun in the 20's when the entire SK&F research department consisted of two scientists, has been, and still is, an important factor in his company's operations. Hundreds of scientists working in academic institutions throughout this country and abroad have been the beneficiaries of this policy.

This research support program brought wide acclaim as exemplified by a grant given to an acquaintance of Dr. Alfred N. Richards in 1929. Upon transmittal of the grant to his friend, Richards remarked, "Certainly the liberality of the terms with which that grant was made and the spirit with which it was made gave me a changed idea of the attitude of industrial administrators to academic investigators."

Also in 1929, Kline directed his firm's reorganization which resulted in complete separation of the wholesaling operations from the research and manufacturing aspects. Smith Kline & French Laboratories emerged as the parent research and manufacturing organization, while the wholesale activities were carried on by Smith Kline & French Incorporated.

The drug firm occupied building (left) in 1887, office annex a few years later.

Specialty products

In the decade after this reorganization, Kline brought about a modification of the entire philosophy of the laboratories when the company began to concentrate its efforts in the research and manufacture of "specialty" products. Thus, in 1936, Smith Kline & French discontinued production and sale of virtually all of its general-line, over-the-counter products and began to emphasize research, development and marketing of "ethical" specialties—products advertised only to the medical profession and dispensed only by pharmacists at the direction of a physician.

Kline's confidence in his own scientists and administrators has given great impetus to the progress of the firm; and his willingness to provide his scientists with an environment approaching the "ivory tower"—so necessary for creative research — has contributed immensely to the company's successful record of recent years.

This confidence in his associates grows out of one of Kline's guiding rules: to select his associates carefully and then delegate considerable authority to them. This was brought out several years ago when Kline was a witness in a trademark lawsuit. Questioned about his associates' activities, he remarked: "I might say that the officers of my corporation are permitted to exercise their functions very independently. That's one of my boasts."

It has not only been in the field of research that Kline has contributed to the advancement of the industry. He recognized that its merchandising methods needed modernization. Perhaps his greatest contribution to progress in this field was to conceive the idea that pharmaceutical products should be introduced to the medical profession by sending samples through the mail. In the early days of his career, product announcements to the medical profession were confined to literature sent through the mail and salesmen who called on doctors.

However, Kline held it to be essential that physicians in large numbers should have an immediate opportunity to evaluate a new drug by actual use. In the early 1920's he therefore directed his company to undertake the sending of actual samples of new products through the mail. Thus, his company established a pattern which still remains an unique aspect of the relationship between the medical profession and the pharmaceutical industry.

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World's leader by far for infant feeding

86% of pediatricians prefer the evaporated milk formula. And more babies have been brought up on formulas made with Carnation Evaporated Milk than any other brand.

NOW IN NEW READY-PREPARED FORM TOO!

Carnalac is Carnation Evaporated Milk with its added Vitamin D, plus carbohydrate.* Mother simply adds water in the amount you recommend, and a balanced formula is assured.

**Natural lactose from the milk, and maltose-dextrin syrup*

The great outdoors

Although Kline has devoted the major portion of his life to advancing medical science and the pharmaceutical industry, his private life has centered around outdoor activities. As an outdoor sportsman he started early, climbing Mt. Blanc in Switzerland at the age of fourteen. At that time he was the youngest to have reached its summit. Kline's love of horses is also well known, being an owner and racing thoroughbreds for many years.

His thoroughbred "Waddon Chase" captured the Grand National and Brooke at Belmont in 1939, and his racing colors have been seen on many of the famous courses throughout the country. He rode his own mounts in hunt meets for many years, and was Master of Foxhounds at the Whitemarsh Valley Hunt Club.

Each winter he manages to visit his plantation in Georgia for some hunting, and in the summer goes to Scotland for grouse shooting. During a trip there several summers ago, his sister received a letter from him which stated: "I'm sorry I've been so long in writing . . ." This brought a spontaneous: "He should be. It is the first time he's written me in 30 years." But the rest of the letter was true to form: "The only reason I am writing you now is that it has been raining and there is no shooting. Am well."

C. Mahlon Kline developed plans for growth.

Test of courage

Kline is also a devoted air traveler despite a harrowing experience in 1929. Following a business visit to Avoset Company, an SK&F milk products subsidiary on the West Coast, he decided to fly back East, despite bad weather, in order to spend the Christmas holidays with his mother and two sisters.

Unfortunately, the plane was forced to land at Indianapolis because of a snow storm. As the plane came in it skidded along the icy runway and crashed. Kline was severely injured. It was through Kline's indomitable cour-

age and strong will—plus the preliminary treatment which he received—that he survived.

Kline also is known by his associates to be a reticent man whose words are delivered with brevity and considerable wit. Informality also rules whenever Kline has to make a speech, whether it is to stockholders or an impressive audience of physicians. He possesses that great gift of putting men at ease. At a conference on aging, in 1949, he called the meeting of eminent physicians to order with these remarks:

"Since I have been finding it increasingly difficult at my age of 69 to be at work everyday by 9:15 A.M., I congratulate you and particularly myself for being here at 9:00 A.M. As a matter of fact, under this program of the 'Clinical Problems of Advancing Years,' I speak to you entirely as the problem and not in the least as one of the discussers of this very important subject. If you will examine my case, I will appreciate it very much, indeed, and send the bill to the company, if you please."

Among his many notable awards, Kline received an honorary doctor of science degree from the University of Pennsylvania in 1957 for his activities in promoting "as a shared enterprise" cooperative research between academic medicine and the pharmaceutical industry.

Contributions and progress

The accomplishment of two generations of Klines is immeasurable. The foresight and leadership of both Mahlon N. and C. Mahlon have made substantial contributions to the progress of medicine and the development of the pharmaceutical industry.

Smith Kline & French Laboratories today stands as a monument to their lives. The headquarters of the Philadelphia pharmaceutical firm is now located in a spacious, well equipped building approximately one-and-a-half miles from the site of George Smith's small apothecary shop. The company's 1958 sales of $124 million were derived from a line of 27 prescription products and 16 over-the-counter products.

Today the extensive research activities of Smith Kline and French Laboratories testify to the prevailing influence of C. Mahlon Kline's philosophies. Over 750 of SK&F's employees are engaged in the firm's Research & Development Division where in 1959 alone the company spent over $12 million.

Other research

Apart from the internal effects of this concentration on research, SK&F is active in considerable outside scientific inquiry. The company supports both basic and applied research projects in hospitals, medical schools and pure-research institutions through grants from the Laboratories and the Smith Kline & French Foundation. The Foundation was established in 1952 to administer grants for charitable, educational and scientific purposes.

In addition, SK&F research is carried on in a number of areas outside of the main company headquarters in Philadelphia. In 1958, SK&F announced the establishment of an independent research organization in Great Britain to supplement the firm's own extensive Research & Development Division in Philadelphia and—of equal importance—to provide the company with a direct link to European science.

At the age of 79, C. Mahlon Kline now serves as honorary chairman of the board. His business capabilities along with his wit and disarming simplicity have earned him the respect and admiration his father had attained. His life gives credence to the old adage, "like father—like son."

"I don't care what he said . . . no one has a liver that interesting."

a new anticonvulsant that "oftentimes will turn the tide" in EPILEPSY

ELIPTEN®

(amino-glutethimide CIBA)

Elipten is a new anticonvulsant chemically unrelated to other antiepileptic agents. Clinical trials in thousands of patients have shown that it controls most types of epilepsy and is especially effective when combined with other anticonvulsants.

Improves Control, Alertness, Learning Ability

With Elipten, more epileptic patients can be completely or adequately controlled. Elipten reduces the frequency of seizures in most types of epilepsy and is often effective in refractory cases, especially when combined with other anticonvulsants. Used adjunctively, it often permits reduced dosage of other drugs, thus minimizing their side effects; in some cases, other drugs can be eliminated.

By obviating or reducing the need for barbiturates, Elipten improves alertness and learning ability in children. It has little or no toxic effect on liver, kidney, or blood.

Forster[1] states: "Elipten ... has a definite role in improving the therapy, particularly of petit mal epilepsy." He notes further that Elipten "... oftentimes will turn the tide when added to partially successful medication." Meyer[2] observes: "... it is useful in the control of petit mal epilepsy and is of particular benefit in those cases where petit mal and generalized convulsions are combined." Lambros[3] notes complete control or marked improvement in 27 of 35 patients treated with Elipten (13 were gradually switched to Elipten alone; 14 were given other anticonvulsants adjunctively). Niswander and Karacan[4] report that in 38 hospitalized psychotic epileptic patients given Elipten grand mal seizures were reduced 25 to 35 per cent. Carter[5] recommends concomitant use of Elipten and diphenylhydantoin sodium "... to enhance effectiveness and reduce the dosage of both drugs."

Complete information on Elipten is available on request.

2/3794MB

SUPPLIED: *Tablets,* 250 mg. (white, scored); bottles of 100.

1. Forster, F. M.: Wisconsin M. J. *58*:375 (July) 1959. 2. Meyer, J. S.: M. Times *87*:743 (June) 1959. 3. Lambros, V. S.: Dis. Nerv. System *19*:349 (Aug.) 1958. 4. Niswander, G. D., and Karacan, I.: Am. J. Psychiat. *116*:260 (Sept.) 1959. 5. Carter, C. H.: Dis. Nerv. System *21*:50 (Jan.) 1960.

CIBA

SUMMIT, NEW JERSEY

Law: Doctor and Nurse

The nurse must exercise reasonable or ordinary care in carrying out her professional duties. She is at all times legally responsible for her acts.

George A. Friedman, M.D., LL.M.

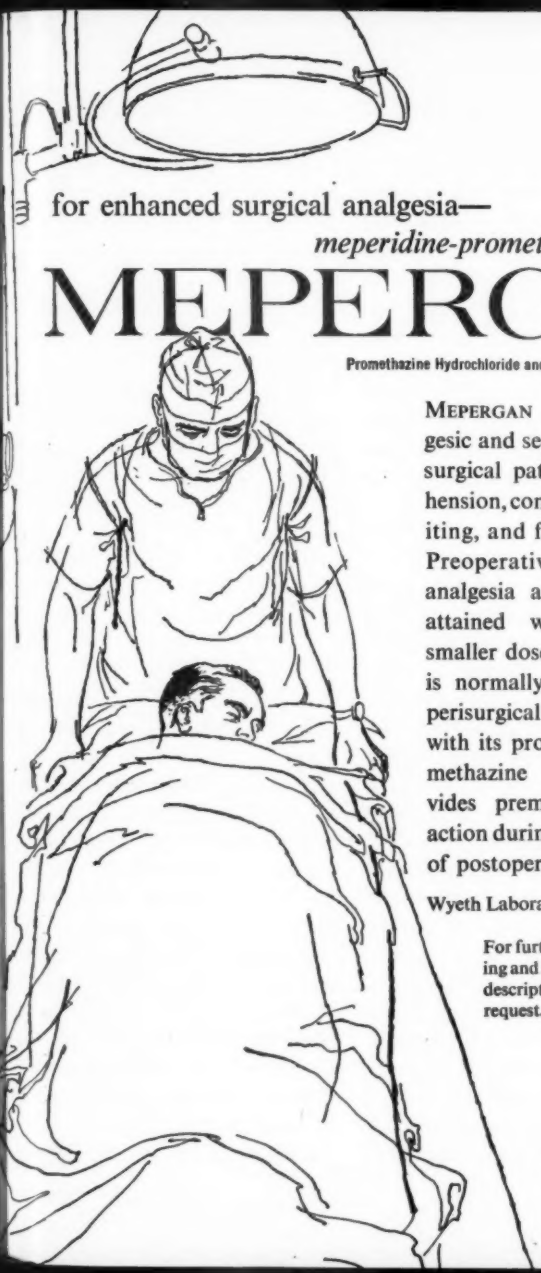
Statutes exist in all states for the registration of professional trained nurses, prescribing the conditions and qualifications for registration. Many states also regulate the licensing of practical nurses.

The nurse must not perform any acts which constitute the practice of medicine. The exception to this rule is that of an emergency. The scope of a nurse's function is greater when acting under instructions of a physician.

Many statutes specifically permit registered nurses who have qualified themselves by a special course of study to administer anesthetics under the direction and in the presence of a physician. In other jurisdictions it has been held by the courts that the instruction of the physician prevents the act from being characterized by the law as the practice of medicine.

Legal responsibility

In the performance of her duties a nurse is required to exercise reasonable care to see that no unnecessary harm comes to her patient. She is legally responsible for her own acts. In some cases she may share her responsibility with others. Cases draw no distinction between the liability of



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the registered, student or practical nurse, licensed or not.

For the most part, cases do not distinguish between malpractice and negligence of a nurse. In one case, however, a nurse was sued for her negligent acts and the question before the court was which statute of limitations was applicable—the two-year statute for malpractice or the three-year statute on negligence. The court held that malpractice was a term applying to a physician, not a nurse.

For jury

The standard of care owed a patient and whether that standard was violated is most often a question for the jury, just as in cases against physicians. The same is true of proximate cause: was the act of the nurse the cause of the injury?

These issues arose in *Cooper v. National Motor Bearing Co., et al.*[1] The nurse was employed by the company to run a first-aid station for employees. A worker employed by the company received a puncture wound on his forehead when another employee let a piece of metal slip from his hand. The injured man went to the nurse for treatment.

She did not probe the wound or examine it, merely applying antiseptic and bandaging it. For three or four months plaintiff was treated by nurse, but he finally requested to see the company physician. The doctor found that he had to remove a basal cell carcinoma.

A verdict of $15,000 was returned against the nurse and the company. The court held that the standard of good nursing care in the community required her to probe the wound for a foreign object. The delay in sending defendant to a physician when she saw the wound failing to heal properly was similarly negligent. There was sufficient evidence also as to proximate cause.

Assisting

A hospital nurse gave the physician formalin instead of the novocain which he requested as an anesthetic for an operation involving removal of a cyst in the pelvic region. Pain accompanying treatment lasted three months, and a scar resulted which interfered with marital relations.

A verdict of $7500 was recovered against the nurse. The hospital was not liable since it was a charitable institution, and the surgeon was not liable since the nurse was not his employee, but the hospital's.[2]

Death resulted from a laparo-

tomy sponge being left in the deceased's abdomen during a Cesarean operation. The charges against the student nurse, responsible for counting the unused sponges, were dismissed. The hospital was not liable because it was a charitable institution.

The supervising nurse was in charge of counting the used sponges, and she reported the sponge count correct.

Judgment

The jury brought in a judgment of $10,000 against the surgeon and the supervising nurse. The surgeon settled for $4500 and on appeal the court held that the nurse was liable for the rest of the judgment.[3]

The case against a nurse was dismissed in *Leonard v. Watsonville Community Hospital.*[4] The nurse assisted in an operation in which a clamp was left in patient's abdomen. There was no evidence that it was the nurse's duty to make an instrument count.

Under direction

A nurse acting under the direction of a physician is not liable for his malpractice. It is the duty of the nurse to "obey and diligently execute the orders of the physician in charge of the patient, unless of course such order is so obviously negligent as to lead any reasonable person to anticipate that substantial injury would result to the patient from the execution of such order or performance of such direction."[5]

The physician placed patient in a sweat cabinet. He was present at all times and instructed the nurse as to the wrapping of patient. Patient was severely burned. *Held:* the nurse was not liable. She could assume the treatment of physician was proper.[6]

A defendant nurse improperly operated a diathermy machine as a result of which plaintiff was severely burned. Plaintiff called to nurse's attention the fact that the machine was too hot. Nurse did not turn down the current

although she pretended to do so.

The court held the nurse was not relieved from responsibility simply because she was acting under the direction of defendant doctor in whose office she worked. She also owed a duty to patient and knew the consequences of applying too much heat or failing to reduce the current.[7]

Communications

In some states statutes have been enacted expressly making communications between nurse and patient privileged from disclosure in courts of law.

In New York the privilege is limited to professional or registered nurses, and is further limited to those communications necessary to enable nurses to act in their professional capacity. Thus a visiting nurse was permitted to testify that the deceased was mentally alert at all times; that his memory was good; that he took an interest in his farm and farm prices, and that he related to the nurse stories of his farm and neighbors.

The witness testified only to what she observed. Nothing which had been said to her by decedent was communicated to enable her to act in her professional capacity.[8]

Most states have statutes which specify that the privilege belongs to physicians. They do not specifically mention nurses. Jurisdictions are divided as to whether these statutes should be construed to include nurses. Those states which include nurses within the privilege do so to prevent the privilege from being thwarted:

"It is often necessary for those who assist the doctor as a nurse . . . to be present at conversations between the patient and doctor, and little good would be subserved, if the lips of the doctor could be sealed by statute as to conversations, but the nurse or attendant might testify to all that was said and everything that was done. The purpose of the law was to protect the right of privacy . . . its very intention might be thwarted by the admission (of the nurse's evidence as testimony)."[9]

The privilege in these jurisdictions is limited to nurses acting as assistant or agent of the doctor and not as an independent person.

A physician on the staff of a hospital claimed that a graduate nurse had disparaged him to his patients. He caused the superintendent of the hospital to take the nurse's name off the registry by threatening to discontinue sending his patients to the hospital. The nurse sued the doctor.

There was no evidence at the

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trial other than the testimony of the doctor as to the derogatory remarks. The nurse denied she made them. It was agreed by all that for a nurse to criticize a doctor to his patient would be a breach of ethics.

The jury found for the nurse. Interference with business relationships and livelihood of a nurse unjustifiably is actionable.[10]

Compensation

In many jurisdictions hospital or industry nurses are covered by workmen's compensation, either by statute or because the employer voluntarily elects to be bound by the statute. In order to be covered the nurse must be an employee, not an independent contractor, and the accident must arise out of the employment.

A professional nurse was assigned by the hospital to a patient at patient's and physician's request. Her name was taken from a list of nurses maintained by the hospital.

"There was no agreement or understanding as to the nature of her duties or the right to control her services. Her hours of employment and the wages she was to receive were covered by an operating schedule maintained between the hospital and the nurses' association."[11]

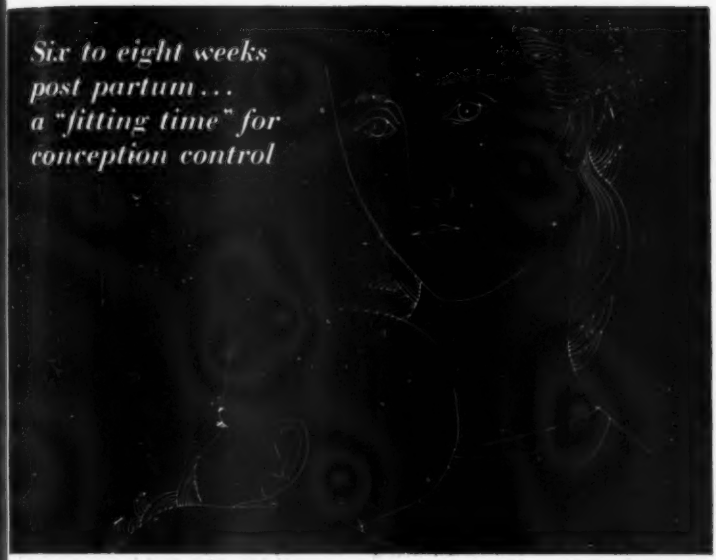
After a week, nurse's finger became infected and she sued patient for compensation under the Workmen's Compensation Act. *Held:* nurse was an independent contractor, and not an employee of patient.

"The judgment of the nurse must frequently be contrary to the wishes of the patient, and in the exercise of their independent calling, it is their undisputed right to follow their own judgment without interference on the part of the patient." The right to control the work of the nurse was not reserved to the patient.

A male nurse was employed by a city hospital. His salary was $110 a month plus three meals a day, including days when he was off duty. On a day when he was off duty he returned to the hospital for dinner. He slipped and fell on the stairs and was injured. *Held:* compensable injury. His presence on the premises was associated with his employment.[12]

Insurance

Nurse was insured by an accident policy which provided coverage against "bodily injury sustained through accidental means and resulting in disability, dismemberment, loss of sight, or death." The policy further stated that "blood poisoning resulting



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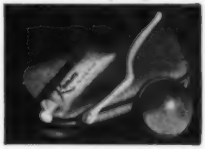

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from a bodily injury shall be deemed to be included in term."

While attending a patient who had blood poisoning the nurse contracted the disease and died. *Held:* the beneficiary under the policy could recover. Death was by bodily injury sustained through accidental means.[13]

Damages

Husband received $36,566.17 damages for the death of his 38-year-old wife. The wife had a life expectancy of 28.96 years. Her 40-year-old husband had an expectancy of 27.61 years. They had been happily married for ten years.

Decedent was a college graduate and registered nurse who had worked for two years after her marriage and again after her husband entered the navy, earning $75-$80 a week. During their marriage the couple had built up a capital of $15,000. The husband testified that he had left financial matters largely if not entirely, to his wife since she was a better manager than he.

A physician was awarded $7000 for the death of his wife. He had a life expectancy of 27.45 years. His wife, apart from housekeeping for her husband, did practical nursing and acted as his receptionist and stenographer. Although the husband remarried 11 months after his wife's death his second wife performed none of these extra services.

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QUIET, PLEASE!

YOUR WIFE'S TALKING

HOW TO HANDLE YOUR PSYCHIATRIST

Nancy Simon

The particular problems that beset the psychiatric resident's wife usually come on with suddenness at the beginning of the residency.

Though you may have been a student's and an intern's wife, your experience is likely to prove inadequate in dealing with the new and highly dynamic situation. The average wife's metamorphosis is rapid: one day a happy, carefree woman, the next a "schizoid, Oedipally-dependent, orally-oriented, castrating member of a neurotic relationship based on a societal need for a familial unit."

Guess whose pronouncement this is?

But let me hasten to add, for wives of future psychiatrists, that this freewheeling labeling occurs only in the first few days or weeks of hubby's exposure to the jargon. The problem is that he has to have *someone* to try it out on. He can't very well spout this kind of stuff to his patients.

The best countermeasure is to stand right up to him, look him in the eye and say, "You don't look so hot to me, either."

Peace

This will bring a shocked response, and he will slink back to his texts wondering what has happened to the intelligent, sensitive woman he married.

By the time he realizes that *nothing* has happened, he will have mastered his technical lingo and will leave your bruised psyche alone.

The next few months will be quite peaceful. Your husband will leave his work at the office and come home eager for the pleasures of the hearth. He'll respond to small talk and show real interest when you tell him that the baby chewed a mouthful of staples while you were hanging up new curtains.

This is a good phase, and you will lull yourself into a false sense of security. Things seem just fine, time passes peacefully.

Nothing's simple

Savor and enjoy this period, for it will not last. After a few weeks you'll realize that your husband seems incapable of replying with a simple yes or no to any of your questions. You'll wonder and worry about this lack of response.

But what could you have done to offend him?

Nothing. It's just that in his training your spouse has been taught that there's no such thing as a simple question. They *all* mean something.

Perfectly true in therapy, I guess, but still awfully disconcerting around the house. It makes you think twice before you even ask him about the weather. The only solution is to approach the problem as if it were a game. (But for heaven's sake, don't let him know that you've caught wise. He'll deny everything.)

Just proceed as though everything were normal:

"Would you like roast lamb for supper, dear?"

"It doesn't really matter."

"Maybe you'd like something else?"

"Whatever you'd like."

"Then lamb will be okay?"

"It really doesn't matter."

Anything wrong?

This sort of thing goes on until you despair of ever again getting a straight answer. And when you reach the point where you can't stand it any more and finally decide to put your foot down, your husband will consider your question a moment, then say, "No, I'd rather not have cereal this morning. How about some of those nice scrambled eggs?"

Just like that, completely un-

aware that he's acting human again.

Your relief is overwhelming. You laugh hysterically and shout, "Hallelujah!"

He looks up at you, concerned. "Are you sure you're not pregnant, dear?"

You've passed the test with flying colors. From here on in you're a pro and can handle just about anything likely to come along.

Having passed through your infancy as a psychiatric resident's wife, you decide that you, too, should read the journals. You read them with him in medical school, didn't you? (And had six different fatal diseases.) And they are in English, aren't they? You know how to read English. Ergo . . .

Underground

So you start reading and try to discuss psychiatric problems with your husband. In all probability he will react as mine did —he'll tell you to go back to the women's magazines because you don't have the necessary grounding in the field. (He's right, and you know it, but it's an insidious thing.)

You go underground. You read when he's on call, or during the day. You find yourself looking at your child with pity. What are you doing to this poor, defenseless creature? What hostilities are you engendering in him, what anxieties? And so you go to the child analytic literature.

You make excuses about not getting at the housework. The dust piles up, dishes don't get done, but you're up on Freud. Suddenly you *know,* in your heart of hearts, that you've ruined a young life. You've produced a bundle of neuroses, you have an autistic child. Your own sweet baby—you've done this to him.

Only Spock

That night, when your husband comes home, you're a nervous wreck. Dinner isn't ready, you've chewed off half of your fingernails, and now the *baby* seems to wear a pitying look.

Most residents' wives will attest to the fact that you get through this stage unscathed. All it takes is the sympathetic ear of your husband and an hour of his time enumerating the baby's virtues. Of course, you knew all the time that you had the best-adjusted, nicest baby around and that you're a top-notch mother, but it's nice to hear it. You usually end up promising faithfully never again to read anything but Spock.

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His turn

In the normal course of events it's at this point you find the tables are turned and you're reassuring your husband. He suddenly realizes that he misses medicine. Good, clean, physical medicine. Like taking out an appendix, or setting a broken leg.

As far as I've been able to tell, this happens when a patient of his suddenly starts resisting therapy. Your husband has spent months with the patient, he should be finishing therapy, and now he's worse, all of a sudden. Your husband's a lousy psychiatrist, he shouldn't have started in the first place, what right has *he* to think he's doing anyone any good?

At just about this time you mention you don't feel too well, maybe you'd better go down to the lab and have a blood sample taken, or go for a checkup. Your husband's eyes light up. During internship he would have sent you to the lab. But now, well, he's a doctor, isn't he?

His microscope comes out of the storage room. His stethoscope is draped over the bedroom door handle where he can get to it quickly. You find the kitchen divided into sterile and nonsterile areas. Every time you put your arm out to reach for the flour you find a blood-pressure cuff around it.

Back in business

Twenty tests later he decides that you're just pretty tired, nothing wrong that a good night's sleep won't cure.

"Of course, if you still have doubts," he says reassuringly, "I'll set up an appointment with Dr. Miller. He's an excellent internist—really knows his stuff."

You nod. "I guess it's each man to his own specialty."

"Yep, that's it. Each man to his own specialty."

Once again he knows he be-

ABOUT THE AUTHOR

The author is married to a resident in psychiatry at an Eastern medical center. "We live in the usual state of confusion that is common with parents of a small child," she writes. "Our son is 16 months old and is being brought up on Spock and common sense. No analytic literature. But we do have a Siamese cat who is slightly pixilated and insists on sleeping in the stove."

longs in his. The troublesome patient has begun to respond again, with gratifying results. You can reach for the flour with confidence now. Your man's in his chosen field, and he's good at it. And he knows it.

Outsiders

One subject I haven't touched on yet, because it's the hardest, is your relations with "outsiders." Most likely your neighbors aren't in psychiatry, probably not even in medicine. When you moved in you met them and liked them, and they liked you. You had coffee with them and exchanged baby-sitting and recipes. Everything was fine. Fine, that is, until they found out your husband's field.

Then, suddenly, things became awfully calm around the house. No kaffeeklatches, no recipes. You'll wonder why until some intrepid soul tells you that they don't want to speak to someone who'll interpret everything they say and read their minds!

In vain you tell them your husband doesn't act that way. You tell them about the only time he seemed to read your mind was when he gave you that perfume for your birthday, and that was only because you taped the ads for it on every inch of available wall space.

It's a lonely life, but have hope. Sooner than you think, your neighbor's husband is going to wander in to borrow something. (All of them do.) Open a can of beer before he can refuse it. Sit him down and let him start talking to your husband. Eventually his wife will wander in, too.

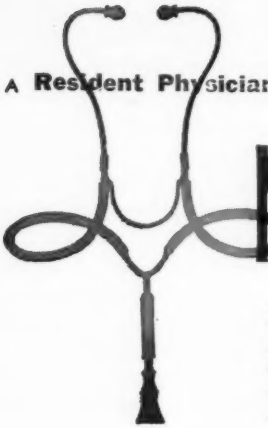
They'll find out for themselves that psychiatrists are nice people, that they can talk about ball scores and gardening and the situation in Washington.

From here on, gal, you've got it made. You can start giving thanks for each perfect day and take the not-so-perfect ones as they come—few and far between.

You're an accepted member of the community, you've weathered the hardships of being a beginning psychiatrist's wife.

And as for your partner in your "neurotic relationship based on a societal need for a familial unit"—well, you know that he's the best husband going and that you never stopped loving him no matter how traumatic things got.

A **Resident Physician** MONTHLY FEATURE



Mediquiz®

These questions were prepared especially for RESIDENT PHYSICIAN *by the Professional Examination Service, a division of the American Public Health Association. Answers will be found on page 168.*

1. An elevated serum alkaline phosphatase may be seen in:

A) Cardiac failure.
B) Hypophosphatemia.
C) Malnutrition.
D) Congenital extrahepatic bile duct atresia.
E) Senile osteoporosis.

2. The oral d-xylose tolerance test is a measure of:

A) Hepatocellular function.
B) Alpha-cell activity.
C) Pancreatic exocrine function.
D) Intestinal absorption.
E) Renal tubular function.

3. Failure to increase a low serum carotene value after oral administration of 15,000 units o.d. x 5 suggests:

A) A malabsorption syndrome.
B) Advanced liver disease.
C) Advanced diabetes.
D) Hyperthyroidism.
E) An inadequate loading dose.

4. A condition in which the serum alkaline phosphatase is *not* elevated is:

A) Congenital extrahepatic duct atresia.
B) Infectious mononucleosis.
C) Congenital intrahepatic duct atresia.
D) Hepatic amyloidosis.
E) Cholangiolitic hepatitis.

5. Failure of a patient with adrenogenital syndrome to respond to cortisone therapy suggests an underlying:

A) Adrenal hyperplasia.
B) Eosinophilic pituitary adenoma.
C) Seminoma.
D) Adrenal tumor.
E) Chromophobe pituitary adenoma.

6. A chylous pericardial effusion suggests:

A) Primary hyperlipemia.
B) Tuberculosis.
C) Whipple's disease.
D) Intrathoracic malignancy.
E) Thoracic duct obstruction.

7. Alveolar-capillary block is present in:

A) Primary atypical pneumonia.
B) Lipoid pneumonia.
C) Ayerza's disease.
D) Silo-Filler's disease.
E) Chronic emphysema.

8. In a patient who has received iodides, circulating thyroxin is best measured by:

A) Protein bound iodine.
B) Butanol extractable iodine.
C) Serum precipitable iodine.
D) Conversion ratio.
E) Renal iodine clearance.

9. Primary hyperparathyroidism is usually due to:

A) Multiple adenomas.
B) A pituitary lesion.
C) A functioning carcinoma.
D) A single adenoma.
E) Diffuse hyperplasia.

10. The serum phosphorus is elevated in:

A) Sprue.
B) Pituitary eosinophilic adenoma.
C) Simmonds' disease.
D) Fluoride poisoning.
E) Hyperparathyroidism.

11. An obese 43 - year - old Puerto Rican female is noted to have jaundice. Laboratory re-

sults show an increase in total cholesterol, with a cephalin flocculation of one plus, a thymol turbidity of five, bromsulfthalein retention of 10 per cent and no urine urobilinogen. Any of the following diseases could be considered as the underlying pathological process in the patient *except:*

A) Chronic pancreatitis.
B) Ascariasis.
C) Primary carcinoma of the duodenum.
D) Schistosomiasis.
E) Carotenemia.

12. Which of the following conditions is *least* likely to be associated with peptic ulcer?

A) An insulinoma.
B) A third degree burn.
C) A parathyroid adenoma.
D) Hyperthrophic pyloric stenosis.
E) Acute bulbar poliomyelitis.

13. An abrupt margin between normal skin and transcutaneous necrosis is characteristic of:

A) A carbuncle.
B) A chemical burn.
C) A herpetic vesicle.
D) A diabetic ulcer.
E) An electrothermal injury.

(Answers on page 168)

What's the Doctor's Name?

He was born at Edinburgh, Scotland, May 22, 1859, and died July 7, 1930.

He was educated at Hodder, Stonyhurst and Edinburgh where he received his Bachelor of Medicine, August 1881.

Although he practiced medicine at Southsea, England, he spent seven months in the Arctic as ship's doctor on a whaler and three on a steamer to the west coast of Africa. The result was two books: *Stark Munro Letters* and *The Captain of the Polestar.*

He is the author of the historical works: *The Great Boer War* (1900) and *History of the British Campaign in France and Flanders* (6 vols.).

His *Story of Waterloo,* a one-act play, furnished Sir Henry

Irving with one of his most successful parts.

In later years, he was the champion of and writer of books on spiritualism including *History of Spiritualism* (2 vols., 1926).

But he is best known as the creator of the most famous character in all English fiction. Vincent Starrett called him "a symbol as familiar as the Nelson Monument or the Tower of London; a name that has become a permanent part of the English language."

From 1887 until the author's death in 1930, the amazing fictional character he created appeared in a total of 60 novels and short stories and has been adapted to Broadway, Hollywood, and TV.

The first of the many adventures of this delightful and durable character is called *A Study in Scarlet.*

His address, "Baker Street," is well known—the only fictional character to be known by a home address—but not as well known as the name of his assistant, John H. Watson, M.D.

The author himself was knighted and appointed Deputy-Lieutenant of Surrey in 1902.

Can you name this doctor?
(Answer on page 168.)

VIEWBOX DIAGNOSIS

(from page 23)

EMPHYSEMATOUS CHOLECYSTITIS

Note gas bubbles in gallbladder lumen, in gallbadder wall and in surrounding tissues.

●

MEDIQUIZ ANSWERS

(from page 162)

1 (A), 2 (C), 3 (A), 4 (A), 5 (D), 6 (C), 7 (D), 8 (B), 9 (D), 10 (B), 11 (E), 12 (D), 13 (E).

●

WHAT'S THE DOCTOR'S NAME

(answer from page 166)

SIR ARTHUR CONAN DOYLE, CREATOR OF SHERLOCK HOLMES

●

RESIDENT RELAXER

(puzzle on page 29)